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AUTHORITY

USACDC ltr, 28 Dec 1971

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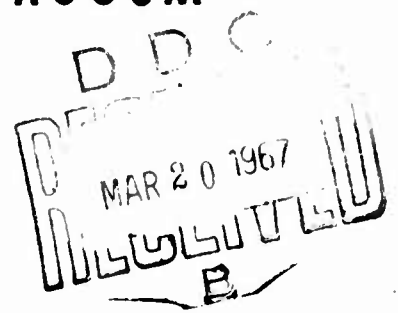
809332

UNITED STATES ARMY COMBAT DEVELOPMENTS COMMAND

FINAL STUDY

**MEDICAL COMMAND, TASCOM
and
MEDICAL BRIGADE, FASCOM
TASTA 70
(ACN 3133)**

December 1966



**Prepared By
UNITED STATES ARMY
COMBAT DEVELOPMENTS COMMAND
MEDICAL SERVICE AGENCY
Fort Sam Houston, Texas**

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UNITED STATES ARMY COMBAT DEVELOPMENTS COMMAND
MEDICAL SERVICE AGENCY
FORT SAM HOUSTON, TEXAS 78234

FINAL STUDY

MEDICAL COMMAND, TASCAM

and

MEDICAL BRIGADE, FASCOM

TASTA-70

(ACN 3133)

December 1966

ACKNOWLEDGMENT

This study is approved by Headquarters, USACDC Combat Service Support Group. Information contained in this study conforms to the Department of the Army approved doctrine study, "The Administrative Support, Theater Army, 1965-1970 (TASTA-70)."

This study is provided for use as a reference document and as a basis for further development of doctrinal literature (field manuals), tables of organization and equipment, basis of issue, and materiel requirements documents.

Comments concerning this study are invited and should be sent direct to the US Army Combat Developments Command Medical Service Agency at Fort Sam Houston, Texas 78234.

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BRIEF

This study presents the functions, organization, and concepts of operation of an Army-wide medical service within a theater of operations for TASTA-70. The Medical Brigade, FASCOM, supports the field army through the employment of subordinate control headquarters, hospitals, evacuation units, and other medical service organizations. The Medical Command, TASCOR, provides command, planning, and continuous operation of the theater-wide medical service by relieving the field army of its patients and providing them hospitalization in the COMMZ. TASCOR is furnished medical service on an area basis. Where appropriate, medical service functions were adapted to automated systems. Type medical service support organizations were structured for twelve, eight, three, and one division forces.

SUMMARY

1. This study presents the functions, organization, and the concepts of operation of an Army-wide medical service within a theater of operations for TASTA-70.

2. The Army Medical Service is a supporting service of the combat elements of the Army and is primarily concerned with the maintenance of the health and fighting efficiency of the individual soldier.

3. Medical service in a theater of operations is continuous and Army wide. It is interzonal and intersectional in character; interzonal in that the efficiency of its operation depends upon the coordination established and maintained between the medical services of the combat and communications zones, and intersectional in that treatment in fixed hospitals and the evacuation of masses of patients in the communications zone normally cannot be limited to area boundaries.

4. The medical brigade of the FASCOM furnishes support to the field army through the employment of medical groups and battalions, hospitalization and evacuation units, and other medical service organizations. Medical support provided includes continuous treatment, hospitalization, patient evacuation, reinforcement of division medical services; dental, veterinary, laboratory, preventive medicine, and medical supply and medical maintenance services.

5. The medical command of the TASCOT provides for the command, planning, and continuous operation of the theater-wide medical service by relieving the field army of its patients and providing treatment facilities for them in the communications zone. Medical service support of the TASCOT is provided on an area basis. The support provided includes hospitalization, patient evacuation; dental, veterinary, laboratory, preventive medicine, and medical supply and medical maintenance services.

6. A type medical service organization was structured for the FASCOM and the TASCOT to support the theater forces included in the basic TASTA-70 study.

7. The principal conclusions are:

a. That the medical service units indicated in this study are the minimum required for a theater of operations under the TASTA-70 concept.

b. That no changes in medical service career programs or the CONUS training base are required.

c. That no new medical service MOS's or medical equipment are required for TASTA-70.

HEADQUARTERS
UNITED STATES ARMY COMBAT DEVELOPMENTS COMMAND
FORT BELVOIR, VIRGINIA 22060

CDCCD-C

15 July 1966

SUBJECT: The Administrative Support, Theater Army 1965-1970 (TASTA-70)

TO: See Distribution

1. References:

- a. Final Draft Study, TASTA-70, dated 28 February 1966.
- b. Letter, HQ, Department of the Army (AGAM-P(M) (7 June 1966) FOR DS DM), dated 8 June 1966, subject as above.
- c. USACDC Draft Study Directive: Combat Service Support 1975 (CSS-75) (U).

2. Purpose. To assign specific responsibilities and tasks among subordinate elements of this command, and to prescribe a time schedule for accomplishing these tasks, in order to:

- a. Provide a doctrinal plan and organizational basis for the Combat Service Support System in the Army in the Field through FY 1970.
- b. Complete and publish a modified TASTA-70 study pursuant to the decisions promulgated in reference 1b.
- c. Provide for the accomplishment of necessary additional study analysis.
- d. Establish a basis for transition and further development of combat service support doctrine from TASTA-70 to the Combat Service Support (CSS) 75 doctrine study.

3. Concept, Scope, and General Guidance.

a. The final study, "The Administrative Support, Theater Army 1965-1970 (TASTA-70)" (ref 1a), was approved by Department of the Army by ref 1b, subject to modification as outlined in this letter and inclosures. The study will be used as doctrinal guidance for the development of derivative studies, Field Manuals (FM), Tables of Organization and Equipment (TOE), data systems, combat service support policies, applicable regulations, and instruction in service schools.

b. TASTA-70 will be modified, revised, completed, and published as a special Department of Army (DA) Field Manual to be designated FM 54-8-T, The

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15 July 1966

SUBJECT: The Administrative Support, Theater Army 1965-1970 (TASTA-70)

Administrative Support Theater Army (TASTA-70) (Test), on or about 31 December 1966.

c. New and revised TOE and TOE changes will be published in an orderly transition from the CO-STAR II organizations to the new and modified organizational structures approved for TASTA-70. These include TOE to be available in the near future and other TASTA-70 Plan TOE being expedited for completion by end CY 66. This will permit early completion of the functional alignment initiated by ROAD 65 and CO-STAR II.

d. Other FM (Test) based on TASTA-70 and its derivative studies will be published and distributed to all major commands by 31 March 1967.

e. TASTA-70 and doctrinal literature based thereon; i.e. FM (Test) and other FM changes and additions, will be reviewed and updated through biennial revision, beginning in FY 68. However, when the basic doctrine study TASTA-70 is completed and published pursuant to reference 1b, and when the CSS 75 doctrine study is initiated, no further revision of TASTA-70 per se, as a study, will be undertaken. Instead, CSS 75 will become the doctrine study vehicle for further development of new and improved doctrinal concepts and organizational structures. Any changes from TASTA-70 which are developed in CSS 75 and its derivative studies and which may be appropriate for implementation through FY 1970, will be incorporated into Special DA Field Manual TASTA-70 (Test) other special DA Field Manual (Test), and in normal FM revisions when specifically approved. This will constitute the biennial update and revision of TASTA-70 which is mentioned in reference 1b. This arrangement is being coordinated with the DA staff.

f. Thus, the USACDC study, "Combat Service Support 1975 (CSS-75)" (ref 1c) will be an evolution of those combat service support concepts approved by DA in TASTA-70. Accordingly, certain follow-on actions outlined herein as required for submission in the TASTA-70 biennial update will be included in the CSS-75 study. Time schedule submission dates will be adjusted in programs to reflect the date required for the submission of CSS-75 when the study directive for that study is finalized. Correlation and USACDC Action Control Numbers should reflect that these actions support "Army Concept Program - Army 75." See Task 6, Inclosure 6.

g. Certain actions directed by reference 1b require study analysis extending beyond the finalization and publication of TASTA-70. Some of these will be accomplished within CSS-75 or as derivative studies of CSS-75. Others may be accomplished within the scope of derivative studies of TASTA-70 which are already underway. Some which are initiated within the scope of TASTA-70 derivative studies may subsequently be reoriented and continued within derivative studies to be directed under CSS-75.

h. There is a requirement to describe clearly in terms of specific doctrine, materiel requirements, and organizational structures, the implications of evolutionary ADPE utilization. This requirement is covered under detailed guidance in Inclosure 10.

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15 July 1966

SUBJECT: The Administrative Support, Theater Army 1965-1970 (TASTA-70)

i. The concept of maintenance outlined in AR 750-1 and AR 750-5 will be followed in developing detailed doctrine and organization through derivative studies, and in providing this doctrine and organization for implementation in doctrinal literature and TOE.

j. Special TOE actions to accomplish necessary transition from CO-STAR II to TASTA-70 are detailed in Task 9. Other TOE and FM changes generated by approval of TASTA-70 and derivative studies will be accomplished through normal TOE/FM changes based on biennial review and other revision actions.

k. For additional, detailed guidance, see Inclosures 1 through 11.

l. The FOUO limitation on dissemination of information on TASTA-70 will remain in effect until further notice. TOE and FM (except special DA FM TASTA-70 (Test) and certain other special DA FM (Test) to be designated) may be published without reference to the FOUO limitation on TASTA-70.

m. These instructions will be reconciled to the final study directive for CSS-75 by this headquarters upon receipt of subordinate headquarters comments and prior to finalization and publication of the CSS-75 directive on or about 31 July 1966.

4. Tasks, responsibility, and timing.

a. To modify, revise, complete, and publish the TASTA-70 study is the responsibility of USACDC Institute of Combined Arms and Support (USACDCICAS) with input and assistance from USACDC Combat Service Support Group (USACDCCSSG), USACDC Combat Support Group and Automatic Data Field Systems Command (ADESC) as specified in Inclosure 1 and Appendices A through M thereto. The final study will be published as a Special Department of the Army Field Manual to be designated DA FM (Test). USACDCICAS will forward one clean master copy to the Adjutant General, Department of the Army through this headquarters by 31 December 1966. When notified that DA FM TASTA-70 (Test) draft has been approved by Commanding General, USACDC and forwarded to The Adjutant General for publication, USACDCICAS will forward 10 copies of the same document to each major command, three copies to each USACDC group and institute, and one copy to each USACDC agency, which reviewed the coordination draft study. See Task 1, Inclosure 1.

b. To restudy the CO-STAR II/TASTA-70 repair parts supply system in light of the proposal by the DA Logistic Systems Board (Brown Board) that repair parts be realigned with maintenance at all echelons, is the responsibility of USACDCCSSG. The Study will be conducted within the scope of CSS-75 derivative studies. The results will be incorporated into the CSS-75 doctrine study. Any approved changes will also be incorporated into the first biennial revision of Special DA FM (Test) TASTA-70. See Task 2, Inclosure 2.

c. Task 3. USACDCCSSG will complete war gaming of low and mid intensity conflict and submit results. Planning for high intensity conflict war

CDCCD-C

15 July 1966

SUBJECT: The Administrative Support, Theater Army 1965-1970 (TASTA-70)

games will continue. See letter, HQ, USACDC, dated 31 May 1966, subject: Transfer of Responsibility for USACDCCSSG Evaluation Program, attached hereto as Inclosure 3, which defines responsibility and prescribes timing for TASTA-70 war gaming actions. USACDCCSSG and USACDCICAS will provide results of TASTA-70 war gaming and summary sheets to this headquarters by 15 October 1966 so as to reach Headquarters DA by 31 October 1966.

d. Methods of providing support to other services and allies will be developed in the CSS-75 doctrine study and its derivative studies, and incorporated into the first biennial revision of Special DA FM (Test) TASTA-70 by USACDCICAS. USACDCICAS and USACDCCSSG will submit any recommended changes to the CSS-75 study directive to this headquarters as soon as possible. See Task 4, Inclosure 4.

e. USACDC Institute of Special Studies (USACDCISS), assisted by USACDCCSSG and USACDCCSG will conduct a study of base development. Results will be provided to USACDCICAS for incorporation into CSS-75. Any new or improved doctrine, materiel requirements, and organizational changes recommended for implementation through FY 7' 11 be accomplished as current projects and correlated within the Army 70 Concept Program. Doctrinal and organizational changes will be incorporated into Special DA FM (Test) TASTA-70, other FM and TOE changes, as appropriate. See Task 5, Inclosure 5.

f. USACDCCSSG and USACDCCSG, in coordination with USACDCICAS, will identify required changes in officer and enlisted MOS structure and submit proposed changes through that headquarters in accordance with established procedures, so as to reach Department of the Army by 31 March 1967.

g. USACDCCSSG will develop by 30 September 1967 a concept for automatic resupply to areas within overseas commands and to theaters of operations for use if automated data systems become inoperative. This will require assistance from USACDCCSG and coordination with US Army Materiel Command (USAMC) and ADFSC. Results of this special project will be provided to USACDCICAS for incorporation into the CSS-75 doctrine study. See Task 7, Inclosure.

h. Task 8. Instructional packets. USACDCCSSG will revise and update the TASTA-70 briefing which was presented to major commands during final coordination, and to the DA Staff, and will publish it in a format suitable for local use and local reproduction of visual aids. Coordinate with USACDCICAS to assure consistency with modifications pursuant to reference 1b and these instructions. Make appropriate distribution to US Continental Army Command and other interested major commands based on direct contact to determine their requirements.

i. Task 9. TOE and FM. USACDCCSSG, USACDCCSG, and USACDCICAS will accomplish TOE and FM follow on actions to TASTA-70 as indicated in Inclosure 8.

j. Task 10. Proposal to redesignate TASCOT headquarters as Theater Army Reorganization. This proposal by the DA Logistics System Board (Brown Board) will be considered in conjunction with the Theater Army 70 Study. Separate

CDCCD-C

15 July 1966

SUBJECT: The Administrative Support, Theater Army 1965-1970 (TASTA-70)

instructions will be issued to USACDCIAS and USACDCICAS. See Task 10, Inclosure 9. Responsible office, Director of Plans, Headquarters USACDC.

k. Task 11. Information articles on TASTA-70 for military periodicals. USACDCSSG will furnish assistance to enable USACDC to prepare articles on TASTA-70 for publication in the DA Officers Call, Military Review, and Army Digest, for publication prior to the end of CY 1966. These articles will emphasize the evolution of combat service support doctrine and organization, and the flexibility of the TASTA-70 structure. The Information Office will publish separate instructions on this requirement. Work should begin on these articles without delay.

l. Proposed time phased schedule of actions directed herein is at Inclosure 11. Any comments on timing should reach this headquarters no later than 27 July 1966 in order to be considered prior to submission of proposed schedule to DA Headquarters.

5. Administrative Instructions.

a. New study actions directed herein which are not already incorporated into a doctrinal or derivative study project within the context of the USACDC concept of operations will be accomplished individually and so as to provide minimum essential analysis and supporting rationale for logical and sound findings and conclusions. No unnecessary scientific support or detailed and elaborate special study effort not directed herein will be undertaken without program approval by proper authority.

b. Commands and agencies requests for input must be in accordance with USAACDC Pamphlet 71-7, USACDC Data Base Procedures.

c. Point of contact at this headquarters is Major R. V. Wills, Doctrine Directorate, Autovon 851-1450, Ext 44448. USACDCICAS and USACDCSSG will forward point of contact to this headquarters.

6. Correlation. This action is identified as USACDC Action Control Number 919 and supports the following:

Army Concept Program	Army 70
Study "Army 70" USACDC Action Control Number	6078
Army Tasks	<ol style="list-style-type: none">1. High Intensity Conflict2. Mid Intensity Conflict3. Low Intensity Conflict Type I4. Low Intensity Conflict Type II5. Air and Missile Defense6. Military Aid to US Civil Authorities7. Complementing of Allied Land Power

CDCCD-C

15 July 1966

SUBJECT: The Administrative Support, Theater Army 1965-1970 (TASTA-70)

Phase	Doctrine
Function	Service Support

Effort expended on projects already listed in the USACDC program will be reported under the USACDC Action Control Number as listed in the program. The ultimate recipient of a task which does not now or by 31 July 1966 have an action control number will initiate the USACDC Form 87 to enter the new project in the USACDC program.

FOR THE COMMANDER:

11 Incl	/s/D. A. VANTINE
	/t/D. A. VANTINE
1. Finalization of TASTA as a Special DA FM (Test)	LTC, AGC Adjutant General
2. Restudy of Repair Parts Supply	
3. Completion of TASTA War Gaming	
4. Support to Other Services and Allies	
5. Base Development Study	
6. Changes to MOS Structure	
7. Concept for Automatic Resupply	
8. TOE and FM	
9. Redesignation of TASCOC Headquarters	
10. Additional Guidance	
11. Proposed Time Phased Schedule	

DISTRIBUTION:

E plus
HQ, USACDCICAS (10)
HQ, USACDCCSSG (10)
Less HQ, USACDC Coordinator for Liaison (all offices)
Army Commands
Miscellaneous

Inclosure 1. Task 1. Finalization of TASTA-70 as a Special DA FM (Test) USACDCICAS with assistance and USACDCADFSC (para 2e and App E) of USACDCCSSG, USACDCCSG (para 2f App F) as specified.

* * * * *

c. Provide essential chaplain, medical, and military police staff capability within the coordinating staff of the major support command headquarters.

* * * * *

e. Retain medical depots under medical control and exclude medical supply from the inventory control centers (ICCS) for the present. Re-examine this matter in CSS 75 and derivative studies.

(f. State specialized requirements for variations from the company size building block concept where appropriate, such as is required in the medical service. Provide for further study in CSS 75 and derivative studies if required.

* * * * *

**HEADQUARTERS
UNITED STATES ARMY COMBAT DEVELOPMENTS COMMAND
COMBAT SERVICE SUPPORT GROUP
Fort Lee, Virginia 23801**

CSSG-DS

11 October 1965

SUBJECT: Supply and Maintenance Command, TASTA-70

TO: Commanding Officer, US Army Combat Developments Command
Transportation Agency, Fort Eustis, Virginia 23604
Commanding Officer, US Army Combat Developments Command
Ordnance Agency, Aberdeen Proving Ground, Maryland 21005
Commanding Officer, US Army Combat Developments Command
Quartermaster Agency, Fort Lee, Virginia 23801
Commanding Officer, US Army Combat Developments Command
Medical Service Agency, Fort Sam Houston, Texas 78234
Commanding Officer, US Army Combat Developments Command
Communications-Electronics Agency, Fort Monmouth, New
Jersey 07703

1. This letter confirms decisions made recently at this headquarters in conjunction with addressees during the course of developing the TASTA-70 draft study. These decisions implement Department of the Army guidance with regard to functionalization of supply and maintenance. Specifically, they affect the Supply and Maintenance Command, TASCOC, by placing general support rail and marine supply and maintenance in the Supply and Maintenance Command under the management of the field depot system. The organizational units affected are TOE 55-247, Diesel-Electric Locomotive Repair Company, 55-248 Railway Supply and Car Repair Company and 55-157 Floating Craft Depot Supply and Maintenance Company. In addition, TOE 55-447, Aircraft Depot Supply Company, has been eliminated and replaced by a new 29-129 Aircraft and Missile Repair Parts Supply Company. TOE 55-158, Amphibian/Landing Craft Maintenance Company (DS/GS), remains temporarily in the Transportation Command, TASCOC, since the company embraces both direct and general support functions. However, this company should be reevaluated during development of the Supply and Maintenance Command input study with a view to transferring the general support functions of this company to the Supply and Maintenance Command.

2. The effect of the above decisions will be incorporated into the development of the Supply and Maintenance Command input study to TASTA-70. Lateral inputs will be submitted to agencies having primary

CSSG-DS

SUBJECT: Supply and Maintenance Command, TASTA-70

cognizance for a given subject area, and due dates for such inputs will be coordinated among the agencies concerned, as appropriate.

3. Additionally, cryptographic and medical supplies will be incorporated into the Supply and Maintenance Command and the field depot system. The control, organization and location of categories and units will be described generally in the referenced study; however, the details of the systems supporting these two categories of supplies are contained in separate TASTA input studies and may be omitted from the Supply and Maintenance Command study, with suitable references.

4. The elimination of the Headquarters, Field Depot Command is concurred in. It should be deleted from the Supply and Maintenance Command input study.

FOR THE COMMANDER:

Copy furnished:
CGUSACDCCAG

DOROTHY M. GORLICKI
Captain, GS
Act Asst AG

**HEADQUARTERS
U. S. ARMY COMBAT DEVELOPMENTS COMMAND
COMBAT SERVICE SUPPORT GROUP
Fort Lee, Virginia 23801**

CSSG-GZ

22 September 1964

SUBJECT: USACDCCSSG Input Project Directive: USACDCMSA 65-2, Medical Command, TASCOR, and USACDCMSA 65-3, Medical Service, FASCOM (Input to CSSG 63-6, TASTA)

**TO: Commanding Officer
U.S. Army Combat Developments Command
Medical Service Agency
ATTN: CDCMSA-CD
Fort Sam Houston, Texas 78234**

1. General. It is requested that a study be undertaken which will develop medical service support to a theater of operations in consonance with the general objectives stated in Chapter 14, Combat Development Objectives Guide.

2. Objective and Scope. To develop a detailed study of the medical service system in a theater of operations for the 1965-1970 time period in support of TASTA-70, to include sufficient detail to permit (a) costing in personnel and major mission equipment and (b) subsequent preparation of TOE and FM's. Study will develop organizations, operating system and procedures, and equipment requirements to support the medical service.

3. References.

a. Conceptual Framework, USACDCCSSG, 31 July 1963, subject: The Administrative Support, Theater Army, 1965-1970 (TASTA-70), with inclosures.

b. FM 8-10, Medical Service, Theater of Operations.

c. FM 101-10, Organizational, Technical and Logistical Data.

d. Letter, CSSG-GZ, USACDCCSSG, 7 July 1964, subject: The Administrative Support, Theater Army, 1965-1970 (TASTA-70).

e. Study, USACDCCAG, 15 November 1963, subject: Reorganization Objectives, Division, Army and Corps - 1970 (RODAC-70) (U).

CSSG-GZ

22 September 1964

SUBJECT: USACDCCSSG Input Project Directive: USACDCMSA 65-2, Medical Command, TASCOR, and USACDCMSA 65-3, Medical Service, FASCOM (Input to CSSG 63-6, TASTA)

f. Study, Initial Draft, USACDCCSSG, subject: The Administrative Support, Theater Army, 1965-1970 (TASTA-70) (to be published.)

g. Study, Office, Deputy Chief of Staff for Military Operations, HQ DA, subject: Theater Type Corps Force (Objective) FY 1965 (U).

h. Study Project USACDCMSA 75-1, USACDCMSA, subject: Medical Workload Resultant from Combined Effects of Chemical, Biological, Nuclear, Improved Conventional and Sophisticated Weapons (U).

i. Study Project USACDCMSA 62-6, USACDCMSA, subject: A Method for Evaluating the Relative Effectiveness of Field Army Medical Support Systems.

j. Study Project USACDCMSA 63-1, USACDCMSA, subject: Effects of Varying Evacuation Policies Upon the U.S. Army.

k. Study, Field Army Requirements for Tactical Communications, 1965-1970 (TACOM) (U), USACDCCARMSA 64-6.

l. Study, Theater Army Communications System Requirements, 1965-1970 (TACS-70) (U), USACDCEA 64-3.

4. Assumptions.

a. The medical service mission will not change during the 1965-1970 time frame.

b. Initial draft study, reference 3f, above, will be available as guidance prior to completion of this study in final draft.

5. Guidance. The following guidance for preparation of the study is furnished:

a. The study will include a determination of the following:

(1) Organizations, manning tables, and equipment lists of FASCOM organizations in support of a RODAC-type field army.

(2) Organizations, manning tables and equipment lists of TASCOR organizations in a communications zone supporting two RODAC-type field armies.

(3) A troop list of medical service organizations in support of a two-division force.

CSSG-GZ

22 September 1964

SUBJECT: USACDCCSSG Input Project Directive: USACDCMSA 65-2, Medical Command, TASCOR, and USACDCMSA 65-3, Medical Service, FASCOM (Input to CSSG 63-6, TASTA)

(4) A troop list of medical service organizations to be incorporated into the 22 Division Force Supplements.

b. In determining medical requirements for control and information, make full use of ADP capabilities currently available or which can reasonably be expected to be available within the time frame under consideration.

c. Emphasis will be placed on designing units of both battalion and company size whose component elements, or at least one component element, may be attached or detached with a minimum of reorganization.

d. Combat forces supported will consist of units depicted in study, Reorganization Objectives, Division, Army and Corps - 1970 (RODAC-70) (U).

e. FM 101-10 (unclassified section) will be utilized for logistical planning data, including support to other services, and will be modified as follows:

(1) The theater is now at D plus 6 months.

(2) The theater medical evacuation policy is 60 days.

(3) The theater supply level is 45 days, including 10 days in field army and in direct support units of COMMZ and 35 days in COMMZ depots.

f. The study will, as a minimum, meet the requirements of reference 3d.

g. The study will evaluate the application of the current medical support system to the TASTA-70 structure and objectives with a view to developing an improved system that is responsive to user and command requirements and more economical.

h. Emphasis should be placed on reducing the ratio of command, staff, and supervisory units and personnel to operating units and personnel.

i. Quantitative workload data and support requirements will be included in the study to support MTEL and future TOE.

CSSG-GZ

22 September 1964

SUBJECT: USACDCCSSG Input Project Directive: USACDCMSA 65-2, Medical Command, TASCOR, and USACDCMSA 65-3, Medical Service, FASCOM (Input to CSSG 63-6, TASTA)

j. MTEL will include all new equipment which is either under development (RDT&E phase) or proposed for development (QMR or SDR established) and which will be available during the time frame 1965-1970. Information on equipment is available, if required, from USACDCCSSG-FM.

k. In addition to meeting the requirements of TASTA-70, this study will be developed to provide the basic operating system for CCIS-70.

l. Where applicable, provision will be made for improvement of combat service support within theaters of operations and reduction of resource requirements in overseas areas by identification of required changes in CONUS operating systems and procedures.

m. MTEL format will be as prescribed in Annex E to reference 3d.

n. To insure that the materiel implications of studies developed by USACDC are recognized and that appropriate follow-up action is taken to process materiel documents, the letter forwarding such studies to this headquarters will contain the following statement: "This study has been reviewed for materiel implications. As a result of this review, it has been determined that this study (will) (will not) generate new materiel objectives or requirements." Where new materiel requirements are involved, the following additional statements will be added: "New materiel requirements generated by this study are indicated in (paragraph) (annex) (appendix) _____. It is recognized that approval of this study by Headquarters, U.S. Army Combat Developments Command imposes an obligation on the appropriate proponent group and agency to initiate and process the necessary materiel requirements documents in support of these requirements."

o. Special emphasis will be placed on holding echelons and numbers of headquarters to a minimum, extending the span of control of headquarters, standardizing organizational structures and staffing patterns for headquarters performing similar functions, and consolidating operating units which perform related tasks.

6. Administration.

a. Coordination. The draft study will be coordinated with the following:

(1) Appropriate Combat Developments agencies.

(2) Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas.

CSSG-GZ

22 September 1964

SUBJECT: USACDCCSSG Input Project Directive: USACDCMSA 65-2, Medical Command, TASCOR, and USACDCMSA 65-3, Medical Service, FASCOM (Input to CSSG 63-6, TASTA)

b. Suspense dates:

- (1) Coordinated draft to USACDCCSSG - 1 May 1965.
- (2) Draft plan TOE - 30 June 1965.
- (3) Force planning guide annex (22 division force) - 1 March 1966.

c. Distribution.

- (1) Coordinated draft - 15 copies to USACDCCSSG.
- (2) Final draft - recommended distribution list will be submitted with final draft.

d. This project is assigned Project Numbers USACDCMSA 65-2 and USACDCMSA 65-3 and appears in paragraphs 1421a(1) and (6), Combat Development Objectives Guide.

FOR THE COMMANDER:

JIM H. HUNT
Major, GS
Asst AG

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COUSACDCCARMSA

**MEDICAL COMMAND, TASCOM
AND
MEDICAL BRIGADE, FASCOM, TASTA-70**

1. Problem. To develop a study of the medical service system in a theater of operations for the 1965-1970 time period in support of TASTA-70, to include sufficient detail to permit costing in personnel, major mission equipment, and to permit subsequent preparation of TOE and FM's. Study will develop organizations, operating systems, procedures, and equipment requirements to support the medical service in accordance with the approved principles of field medical service (see Annex C).

2. Assumptions. The medical brigade will exercise command and control of the medical service in the field army and a medical command will exercise command and control of the medical service in the COMMZ.

3. Facts.

a. The TASTA-70 concept is a logical extension of CO-STAR and develops concepts of combat service support within the COMMZ.

b. Medical service functions are included in the ADSAF program. Automatic data processing systems (ADPS) will become a part of medical operating procedures where automation will be beneficial to the Army Medical Service in support of combat operations.

4. Discussion.

a. General.

(1) The Army Medical Service supports all elements of the Army and is primarily concerned with maintaining the health and fighting efficiency of the individual soldier. The mission of the medical service in a theater of operations is to conserve manpower by recommending, supervising, and implementing measures for safeguarding the health of the troops through effective medical care and treatment, early return to duty, and rapid and orderly evacuation for the sick and wounded.

(2) General responsibilities.

- (a) The evacuation, care, and treatment of patients.
- (b) The recommending of measures necessary to insure the health of troops.
- (c) Assistance to civil affairs in public health matters.
- (d) Establishing requirements and priorities for medical supply and maintenance services.

(e) The training of medical service personnel and supervision of the training of all other personnel in hygiene, first aid, and military sanitation.

(f) The preparation, classification, and preservation of records of sick and wounded for the information and use of higher authority in future planning and for assistance in the future adjudication of claims.

(g) The submission of timely information and recommendations upon all matters within the scope of the medical mission.

(h) The evacuation, care, and treatment of military animals.

(i) The provision of veterinary food inspection service.

(j) The provision of dental service.

(3) Medical plans and operations.

(a) Adequate and timely planning is necessary for effective operation of the theater medical service.

(b) Medical service must be planned and operated in conformity with the plans and general policies of the commander. The plans and intentions of the commander must be made known to the medical service so that timely recommendations can be made.

(c) Effectiveness of medical service frequently is a function of time. Simple measures, instituted early, often contribute more to combat efficiency than more elaborate measures instituted too late.

(d) Medical plans are adequate only when they provide employable and sufficient means within the theater of operations.

(e) Casualties never adjust themselves to conform to the medical means available at a given point at a given time. Therefore, planning must incorporate measures for meeting unpredictable peakloads.

(f) Any medical decision must be based on the constantly interplaying factors of time, distance, dispersion, casualty rates, distribution of units, evacuation policies, available methods of evacuation, availability and priority of equipment and transportation, the time lag between the requisition and development of hospital plant sites, the necessity for providing a reserve, and the ever-changing strategic and tactical situation. Not one of these factors is entirely independent of the other.

(4) Functional organization.

(a) Levels of Army Medical Service. Medical service in a theater of operations is organized into four functional levels. They are unit, division, field army, and communications zone medical services.

1. Unit medical service. Unit medical service is normally provided by medical service elements which are organic to units the size of a battalion/squadron or higher of the arms and services (except medical). Units without organic elements are furnished unit medical service on an area basis or by the attachment of medical service personnel. Unit level medical service includes the provision of emergency medical treatment; establishing and operation of aid station(s) for the reception, sorting, and temporary treatment of patients; operation of dispensaries for the routine care and treatment of the sick and injured; and medical staff advice concerning unit sanitation, disease prevention, and the health of the command.

2. Division medical service. This is a highly mobile medical service which is provided by a medical battalion organic to the Support Command of Army divisions. Division level medical service includes the evacuation of patients from unit aid stations (dispensaries); the operation of division clearing station(s); and the furnishing of medical supply and emergency dental service for the division.

3. Field army medical service. This level of medical service directly supports the medical service of divisions and provides all hospitalization forward of the army rear boundary. Medical support of nondivisional units is provided on an area basis. The medical service within the field army is tailored to the mission, composition of the force, geographical area of operations, and includes all functions of medical service.

4. Communications zone medical service. This level of medical service directly supports the combat zone by relieving field army medical facilities of their patients and by providing specialized medical care and treatment within large fixed hospitals of the communications zone. Medical support, to include all medical service functions, is also provided to troops of the communications zone on an area basis.

(b) Area medical service. This concept of medical service involves the allocation of medical means to support geographical areas. It includes the provision of unit level medical service to organizations having no organic medical service personnel and the provision of required higher levels of medical support. Under the area medical service concept, means are deployed to support nondivisional forces in the combat zone and all forces of the communications zone. Medical units required for this service are allocated on the basis of troop strengths to be supported.

(5) Treatment and evacuation system (see Figure 1).

(a) Evacuation is the process of removing patients from the battlefield or other location and subsequently moving them through the evacuation system. The term "evacuation system" is applied to the linear system of successive units and installations engaged in the collection, treatment, transportation, and hospitalization of the sick and wounded. The most forward installation of an evacuation system in a theater of operations is usually an aid station and the rearmost installation a general hospital. The forward installations are mobile, small, and numerous. From the line of contact to the theater rear, each successive medical installation provides a more specialized type of medical care.

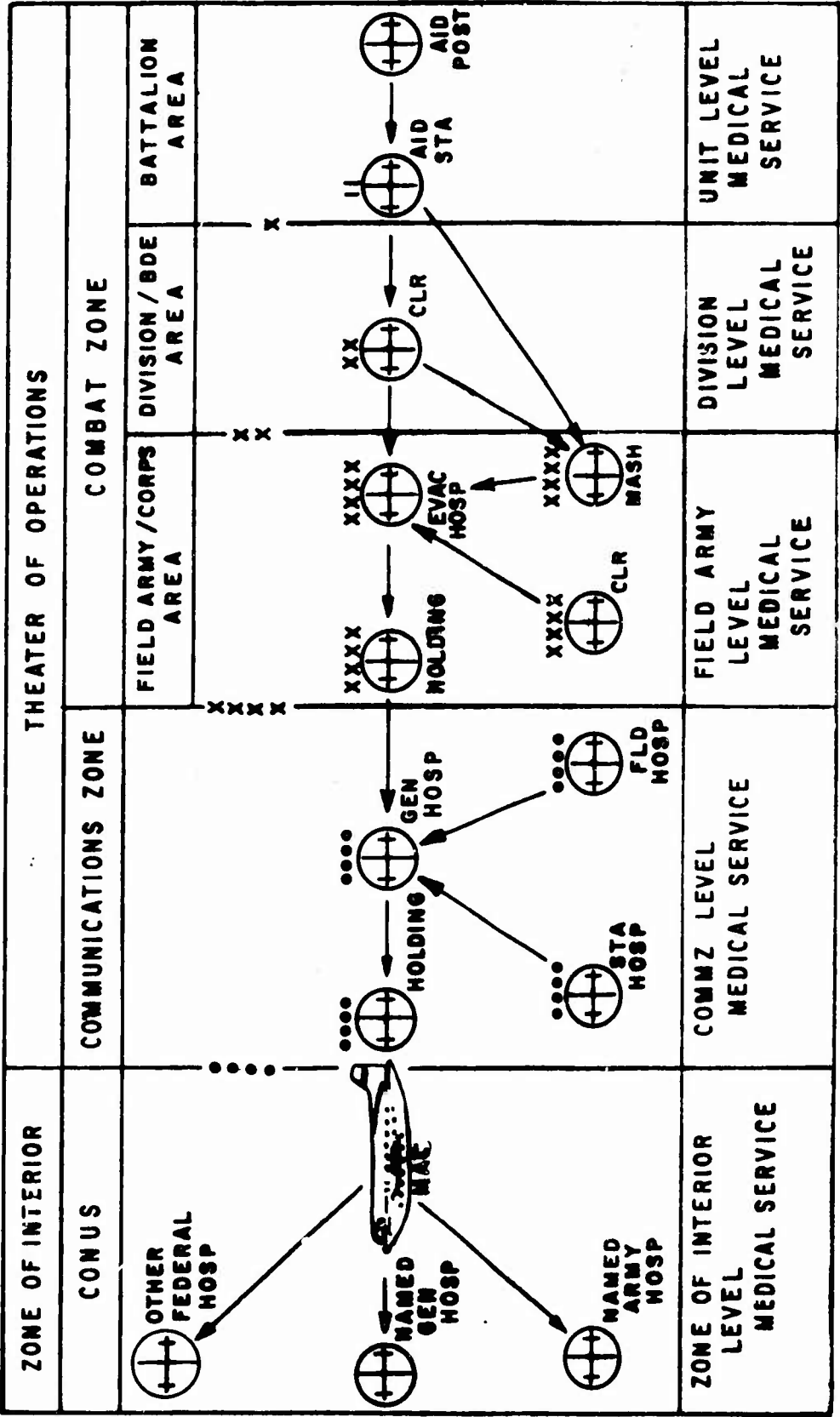


FIGURE 1. MEDICAL EVACUATION SYSTEM

(b) Major problems of evacuation. One of the most difficult medical tasks, and in combat one of the most important, is the evacuation of patients. Commanders at all levels must realize the magnitude and the importance of this function. The evacuation of patients is in the nature of a major withdrawal. The task is difficult under the most favorable circumstances because of the numbers involved and other complicating factors. In forward areas especially, evacuation may meet with trying conditions of weather, terrain, and combat. Evacuation must be made against a constant forward flow of combat troops and supplies and with a minimum of interference to these activities. Patients must be gathered as individuals from the most forward elements of the combat forces; they will require individual care and treatment through all stages of their evacuation. Efficient evacuation is expensive in manpower and transportation means. Throughout the evacuation system, property exchange must be carried on in spite of difficulties confronting such a procedure.

(8) Hospitalization and patient care.

(a) The term "hospitalization" is used to indicate the medical care and treatment provided at a hospital for serious cases ^{or} ~~of~~ those needing care for a period of time.

1. Objective. The objective of all hospitalization is to return a maximum number of patients to duty within a minimum period. Such individuals, because of previous training and experience, are the most valuable of all replacements. A certain proportion of patients recover without being fit for duty with combat or combat support units. Their disposition will be in conformity with theater policies.

2. Classifications. Hospitals are classified as fixed and nonfixed. Fixed hospitals include numbered general hospitals and station hospitals. Nonfixed hospitals include mobile army surgical hospitals and evacuation hospitals. When required, the field hospital may be used in either capacity.

(b) Concept of patient care. The highest standards of medical practice are demanded at all times and under all conditions. The idealism that characterizes the practice of medicine is challenged to demonstrate itself under conditions not encountered in civil practice. However, the peculiar relationship between the patient and physician in civil practice under static conditions is unsuited to and impractical under the dynamic conditions that exist in a theater of operations and, in particular, under mass casualty situations. Under dynamic conditions, medical means, always limited, must be so distributed as to render the greatest service to the greatest number. To devote a disproportionate amount of time and effort to one patient at the expense of the treatment of the mass of other patients is to subordinate the common welfare of all to one individual. It is important that emphasis be placed on the treatment of those conditions commonly encountered in military practice rather than on rare and unusual type cases. The orderly processes and policies of evacuation are not to be hindered because of scientific interest in certain patients.

(9) Interdependence of evacuation and hospitalization. Each of these functions is dependent on the other for its efficient operation. Evacuation and hospitalization must always be considered jointly. Sick and wounded

personnel must be properly prepared for evacuation and given constant care and treatment en route. The location of hospitals near good lines of communication is most desirable. So far as practicable, fixed hospitals will be located on principal axes of travel. The availability of sufficient fixed beds alone does not solve the problem of the medical service; there must also be sufficient means whereby patients can be transported to these hospitals and effectively distributed among them.

(10) Evacuation policy. In order to plan and operate a medical service efficiently, it is necessary to know to what extent patients will be retained for treatment at a given level of service. This is done by considering the patient in the light of the length of time it is anticipated will be required to return him to duty. Thus, in planning a hospital system, it is necessary to decide, or assume, that it will retain for treatment only those patients who will return to duty within a given period. This period, in days, is referred to as the evacuation policy. In another sense, this restriction is used as an operational tool. If the hospitals at a given echelon are crowded, the surgeon reduces the number of patients retained, by directing a lesser evacuation policy. The evacuation policy at any level has a significant effect upon the requirements of the next higher echelon of medical service, not only from the standpoint of hospital facilities, but also in evacuation means. This is particularly true at the theater level. For this reason, the evacuation policy of a joint theater of operations is established by the Secretary of Defense with the advice of the Joint Chiefs of Staff, and upon recommendation of the theater commander.

(11) Medical regulating.

(a) Careful control of the evacuation of patients to hospitals is necessary to effect an even distribution of cases; to assure adequate beds for current and anticipated needs; and to route patients requiring specialized treatment to the proper installations. Rigid control is maintained over the evacuation of patients in need of surgery to prevent surgical backlogs in hospital facilities.

(b) Close coordination must be maintained between the medical service of FASCOM and TASCOT to determine the number and location of patients within the FASCOM awaiting evacuation and the number and location of available beds in the TASCOT. The medical command commander must also ascertain the number and location of patients within TASCOT awaiting further evacuation to the zone of interior. Availability of this information permits the allocation of beds for the movement of patients to hospitals within the TASCOT. The collation of all the above information facilitates the scheduling of patients for evacuation to the zone of interior.

(12) Patient accounting and medical statistics.

(a) This functional area is that process which provides for the collection, recording, summarizing, and reporting of data regarding patients undergoing treatment and/or evacuation. It includes the responsibility for satisfying essential patient data requirements of elements or agencies superior to, or in support of, medical treatment facilities in a theater of operations.

(b) The operational objectives of patient accounting are as follows:

1. To establish a record on each individual entering a medical treatment facility that reflects the manner and source from which the patient was admitted and his specific medical and administrative characteristics at the time of admission.

2. To maintain individual patient records and records files by entering all subsequent changes in patient status.

3. To produce timely reports of operational interest.

4. To provide current statistics and information of historical nature.

5. To support Adjutant General personnel strength accounting procedures on a continuing basis by providing the names and status of all individuals admitted to medical facilities.

(13) Medical supply and maintenance.

(a) Surgeons at each level of command are responsible for recommending policies and determining requirements and priorities for medical supply and medical equipment maintenance service.

(b) In transferring a patient from one medical installation to another there are certain medical properties that cannot well be separated from him. Such property includes blankets, splints, tourniquets, and litters. To prevent rapid and unnecessary depletion of the supplies and equipment of the transferring unit, the receiving unit is charged with turning over to the transferring unit an equal number of the same items of medical property. This procedure is termed property exchange and must be carried out to the fullest extent possible. However, because of the tactical situation and other varying conditions, there will be occasions when property exchange cannot be accomplished. Consequently, the amount of equipment and supplies required for the property exchange system should be considered when determining supply levels.

(c) The Army Medical Depot (TOE 8-667) and the Medical Depot (TOE 8-187) are under the command management of the medical brigade and the medical command, respectively. The medical depots will contain only medical supplies and equipment and will be physically located as a separate storage location. Segregation of medical supplies from mixed shipments coming into the theater will occur at field depot complexes and will then be forwarded to a medical depot(s). Medical depots will perform both a supply and maintenance mission which consists of both general and direct support. When required, medical depots may be augmented with cellular supply detachments of TOE 8-500. Direct support is provided on a supply point distribution basis. The medical depot located in the combat zone consists of a base platoon and three advance platoons. The base platoon is normally located centrally within the field army service area and has both GS and DS functions. Advance platoons are located in corps areas and provide similar functions for supported units. With few

exceptions, medical materiel is used exclusively by medical units for the care and treatment of patients. Under the Geneva Convention, and in accordance with the rules of land warfare, medical supplies, as well as medical facilities, patients, and medical personnel are entitled to protection from direct enemy action.

(d) The oversea commander may be responsible for providing medical supplies for the prevention and treatment of diseases among the civilian population in liberated and occupied areas. Civil Affairs units are responsible for estimating requirements, recommending allocations, and planning for the method of distribution of medical supplies to civilians.

(14) Veterinary service.

(a) The Veterinary service is concerned with the wholesomeness of subsistence; the control of food-borne and zoonotic diseases; providing assistance to the preventive medicine program; and the maintenance of the health of military animals.

(b) Responsibilities of the veterinary service in a theater of operations include: inspections and recommendations concerning any possible contamination of food supplies and food-producing animals with chemical, biological, and radiological agents; planning for the prevention and control of animal diseases transmissible to troops and civil populations; formulation of sanitary standards for the handling and storage of food products from the time of receipt or procurement in the theater until issued to troop units; recommendations and sanitary inspections concerning the operation of theater food processing and distribution establishments; the maintenance of technical control over veterinary units and personnel; and provisions for the evacuation, treatment, and hospitalization of military animals.

(15) Dental service.

(a) The dental service in the theater of operations is a component of the Army Medical Service and as such shares the responsibility for the preservation of the strength and effectiveness of the command. Its mission is accomplished by the establishment of dental services throughout the theater in a manner designed to provide effective dental care and treatment, and to prevent excessive evacuation to the rear of individuals requiring emergency or routine dental services.

(b) General responsibilities of the dental service.

1. To furnish emergency and routine dental care for members of the command and others as may be designated by the commander.

2. To conduct inspections of the command to determine requirements and priorities of dental care.

3. To recommend dental preventive measures designed to reduce the incidence of dental disease and to supervise the training of all personnel in matters of oral hygiene.

4. To coordinate the dental service with other services of the command.

5. To develop, prepare, and recommend plans, policies, and procedures for the operation of the dental service of the command.

6. To prepare, consolidate, and evaluate routine and special dental reports and records for the information of the command and higher authority, and for use in the planning and operation of the dental service of the command.

7. To train all personnel assigned to the dental service.

8. To recommend policies, requirements, and priorities for dental supplies and equipment maintenance services.

b. Effect of TASTA-70 concepts on medical training.

(1) Training. A careful evaluation of the roles of medical personnel assigned to medical service units to support the TASTA-70 concept reveals that no changes from the current training objectives will be required. At the present time there is no indication that new medical MOS's will be required despite the introduction of automatic data processing equipment into medical units.

(2) Career patterns. An examination of the medical organizations and systems included in TASTA-70 indicates that the current career patterns for medical personnel will be adequate.

c. Materiel requirements for TASTA-70.

(1) The development of medical organizations and systems in support of TASTA-70 did not require the addition of new items of medical equipment. However, normal technological development of medical equipment will result in the introduction of some new items during the time frame embraced by TASTA-70.

(2) It was determined during the development of the study that an on-line input/output (I/O) device for entry into computer complexes would be required in selected medical facilities and command headquarters. Another means of communication, compatible with the language and format of the I/O device mentioned above, is required to support the processing of medical functions by an ADP system (see Annex F).

d. Medical service in the FASCOM (see Annex A).

e. Medical service in the COMMZ (see Annex B).

5. Conclusions.

a. That the medical service proposed in this study and the medical troop lists contained in Annex E are the minimum essential required for a theater of operations under the TASTA-70 concept.

b. That medical career programs do not require revision for TASTA-70.

c. That no new medical MOS's are required to support TASTA-70. However, there will be a need for experienced medical service personnel with special training in systems analysis to develop and revise systems designed for the Army Medical Service.

d. That the ADSAF program has not progressed to the point where a firm position can be made regarding ADP, priorities, and amount of computer time needed to satisfy medical requirements.

e. That the only new equipment requirements presently known to be generated by TASTA-70 are requirements for I/O devices compatible with the ADPS.

6. Recommendations.

a. That the proposed medical service in this study be approved for the purpose of revising pertinent field manuals.

b. That the Army Medical Service troop lists in Annex E be approved as the minimum essential medical units required for the designated forces.

ANNEX A

ARMY MEDICAL SERVICE IN FASCOM

1. Purpose. This annex will present the general considerations of Army Medical Service required for the field army under the TASTA-70 concept.

2. General.

a. Mission. The mission of the field army medical service is to conserve the fighting strength through maximum reduction of noneffective rates and the provision of the highest possible standard of health services.

b. Functions of the field army medical service.

(1) Furnish preventive medicine.

(2) Relieve the divisions of their wounded, injured, and sick to maintain maximum combat effectiveness and tactical mobility.

(3) Relieve field army units, other than divisions, of their wounded, injured, and sick.

(4) Provide evacuation and hospitalization.

(5) Effect maximum restoration of personnel to duty status within terms of the evacuation policy.

(6) Furnish area medical service, as required.

(7) Provide medical reinforcement.

(8) Furnish laboratory service.

(9) Furnish dental service.

(10) Furnish veterinary service.

(11) Provide medical support for prisoners of war and civilian internees, as required.

(12) Provide medical support for civil affairs activities, as required.

(13) Provide medical supply and maintenance support.

c. The field army surgeon.

(1) Functions, responsibilities, and duties. The field army surgeon is a special staff officer of the field army commander. He is responsible for keeping the commander and the staff informed on the state of the health of the command and on the medical aspects of combat

effectiveness and combat operations. As the principal medical staff officer, he advises the commander and the staff on all medical matters. His duties normally include the following:

- (a) Developing, preparing, and coordinating the broad medical policies of the command.
- (b) Developing, preparing, and coordinating the medical portions of Army plans.
- (c) Providing current information on the Army medical situation to the surgeons of the next higher and subordinate headquarters.
- (d) Maintaining close liaison with the civil affairs officer on medical requirements.
- (e) Exercising medical professional and technical control of field army medical service activities.
- (f) Recommending the assignment and reassignment of AMEDS personnel in the field army.
- (g) Maintaining a chronological record of medical service operations, activities, events, and other information of historical significance.
- (h) Furnishing all medical professional consultation services to the field army.
- (i) Preparing or consolidating medical statistical and other reports as required.
- (j) Recommending policies and determining requirements and priorities for medical supply and medical equipment maintenance services.

(2) Command and staff relationships. The field army surgeon functions under the general staff supervision of the ACoS G1 and coordinates medical matters, as appropriate, with other members of the general and special staff. On medical professional and technical matters affecting the health of the command and combat operations, he has direct access to the field army commander. Coordination with the surgeons of higher and subordinate headquarters is through command channels, except for direct coordination of professional and technical matters. Since the field army medical service is intersectional and continuous, medical staff problems at all levels are interrelated. Therefore, in accomplishing the medical mission, medical staffs at all levels supplement each other.

d. Medical service in the FASCOM.

- (1) In addition to the medical brigade, there is a medical branch organic to the ACS/Personnel, FASCOM.

(2) There is no FASCOM surgeon. The FASCOM commander may, at his discretion, designate either the medical brigade commander or the medical staff officer assigned to the medical branch, ACS/Personnel to act in this capacity. When one of the above is designated the FASCOM surgeon, he will assume the functions, responsibilities, and duties of a surgeon.

(3) The medical branch, ACS/Personnel, consists of a medical staff officer, medical plans officer, medical administrative assistant and enlisted assistants. The medical staff officer is authorized direct access to the commander on medical matters of command interest.

(4) The functions of the medical staff officer are to:

(a) Advise the commander and staff on professional technical medical matters.

(b) Develop, prepare, and coordinate with the medical brigade, the medical portions of FASCOM plans and policies.

(c) Make plans and recommendations for the procurement and assignment of medical units to the medical brigade.

(d) Exercise technical supervision over medical training throughout the command including sanitation, first aid, and hygiene for all troops.

(e) Evaluate and disseminate medical intelligence in coordination with ACS/Security, Plans and Operations.

(f) Advise and assist ACS/Civil Affairs in planning and coordinating civil public health services.

(g) Plan and coordinate the medical aspects of rear area security and damage control within the FASCOM area of responsibility.

e. Medical service in the support brigade.

(1) General. The staff of the support brigade does not include a surgeon. Therefore, medical staff services, as required, are provided by the commander of the medical group supporting the brigade.

(2) Functions. In his role as advisor for the support brigade commander, the medical group commander advises on the health of the command, medical service support requirements, and provides information concerning medical professional and technical matters.

f. Medical service in the corps.

(1) General. Normally, there are no medical units organic to a corps. The medical brigade provides a medical group with appropriate attached medical units to meet support requirements. These units provide

unit and field army level medical service to the organic and attached units of the corps on an area support basis.

(2) The corps surgeon. The corps surgeon is a special staff officer of the corps commander. He is responsible for keeping the commander and staff informed on the health of the command and the medical support situation. As the principal medical staff officer, he advises the commander and staff on the medical aspects of matters affecting operations. His duties normally include:

(a) Developing medical policies in agreement with policies of higher headquarters and implementing procedures to insure adherence to these policies within the corps.

(b) Evaluating, coordinating, and implementing medical plans in agreement with plans of higher headquarters.

(c) Exercising staff supervision of medical service within the corps and divisions.

(d) Coordinating medical support of corps operations with the FASCOM medical brigade commander.

(e) Maintaining liaison with the surgeons of higher and subordinate headquarters.

(f) Processing medical records and reports as required.

(g) Monitoring medical supply activities with emphasis on critical items affecting medical support of the combat mission.

(h) Monitoring AMEDS personnel matters to include recommendations for personnel assignment.

(3) Staff relationships. The corps surgeon operates under the general staff supervision of the corps ACoS G1 and coordinates medical matters with other members of the corps staff. He has direct access to the corps commander on professional and technical matters affecting the health of the command and on medical matters affecting operations. Coordination with the surgeons and medical commanders of higher subordinate and lateral headquarters is through command channels, except for medical professional and technical matters which may be coordinated direct.

(4) Independent corps operations.

(a) When a corps is assigned an independent mission, combat service support functions and responsibilities are added. A corps support command (COSCOM) is organized and tailored to the mission. Under these circumstances, the surgeon of the independent corps must assume duties similar to those of the Army surgeon.

(b) Normally, a medical group is tailored to the mission and attached to the Corps Support Command (COSCOM) as the operating medical command of the independent corps. The group commander with his increased staff (See Part B, TOE 8-122) must assume duties and responsibilities similar in scope to those normally performed by the medical brigade commander and his staff.

g. Medical service provided the field army by the medical brigade.

(1) Evacuation and treatment. Evacuation is the process of moving patients to and through successive medical treatment facilities. For each patient that is moved to the rear there must be a replacement brought forward; therefore, it is essential that the medical service does not evacuate patients that can be rehabilitated in medical installations of the field army. A critical evaluation of the time required for rehabilitation of each patient, as opposed to the immobilization of medical installations by the accumulation of patients, must be made prior to evacuation from combat zone installations.

(a) From divisions and corps. The responsibility for evacuating patients normally passes to the field army at division clearing stations; however, field army provides aeromedical evacuation of all categories of patients from any point within the division to field army medical treatment facilities. Patients requiring evacuation from clearing stations are moved as soon as the patient's condition permits; this prompt evacuation is essential to avoid immobilizing the clearing stations with large numbers of patients. Normally, patients are evacuated to mobile army surgical or evacuation hospitals by ground or air ambulance units.

(b) From units of Army troops. The field army medical service, with its organic ambulances, collects patients from dispensaries and aid stations of units to the rear of division boundaries and transports them to mobile army surgical or evacuation hospitals, or, on occasion, to field army clearing stations. Patients from field army clearing stations normally are taken to an evacuation hospital, an army convalescent center, or to units established for the treatment of special type cases.

(c) Rear termini of field army evacuation system. Normally, evacuation hospitals are the rearmost units in the field army evacuation system. At these installations the responsibility for evacuation passes to the TASCOC commander. However, if a medical holding company or some other unit is employed to operate a medical holding facility anywhere in the evacuation system, the field army medical service assumes the responsibility for evacuating patients from hospitals to the holding installation even though it may be rearward of the evacuation hospitals. Air evacuation of patients from the combat zone to the communications zone is the responsibility of the Air Force. Ground evacuation of the combat zone is accomplished by COMMZ ambulance companies, rail ambulance trains, or in emergency by other type ground transport.

(2) Evacuation policy. It is not advisable for the field army surgeon to recommend a long range evacuation policy for the field army area. Certain factors, which may vary from day to day, determine the length of time

patients may be held in field army hospitals. Among these factors are patient admission and disposition rates, the number of available hospital beds within the field army, the capabilities of hospital professional staffs, the tactical situation, and the availability of COMMZ transportation and hospitals.

(3) Hospitalization.

(a) General. The employment of field army hospitals in the combat zone is governed by two basic principles: First, hospitalization is provided as close as practical to the troops requiring it; and second, the maximum number of personnel are returned to duty within the combat zone in order to conserve the fighting combat strength. Although hospitalization is provided in the forward areas for patients for whom it is essential, the hospitalization of all serious patients in the most forward units should be avoided. Medical cases should be distributed to hospitals according to type and professional capabilities of hospital staffs. Evacuation is controlled to effect a distribution of cases so that each patient can receive the treatment required.

(b) Types of field army hospitals. Combat zone hospitals include mobile army surgical and evacuation hospitals. Facilities for the treatment of certain conditions, such as psychiatric disorders, may be established by the addition of professional teams and extra equipment to medical clearing companies.

(c) Location of field army hospitals. Field army hospitals should be located near the troops to be supported and accessible, both from forward and rear areas, by normal means of transport. Sites are undesirable if they cannot be easily evacuated and cannot effectively display the Geneva Cross. They should not be located near supply or ammunition dumps, important crossroads, or other potential targets of enemy air attack.

(4) Medical regulating. Medical regulating is the operating procedure controlling the evacuation of patients from division and field army medical units to appropriate field army hospitals utilizing the most effective means of transportation. The information required for effective medical regulating includes the number and location of patients to be evacuated; the locations, vacant beds, and surgical backlog of the field army hospitals; and the available transportation. An efficient working evacuation system will decrease the number of times a patient is handled between the division clearing station and the field army hospital, and between one field army hospital and another. Rigid control of the system is maintained especially for the evacuation of patients awaiting surgery.

3. Current Medical Service Organization and Operations in the FASCOM.
(See Appendix I to Annex A.)

4. Proposed Medical Service Organization and Operational Concepts in the FASCOM. (See Appendix II to Annex A.)

APPENDIX I TO ANNEX A

CURRENT MEDICAL SERVICE ORGANIZATION AND OPERATIONS IN THE FASCOM

1. The purpose of this appendix is to illustrate current medical service organization and operations for the FASCOM under the CO-STAR concept.

2. The Medical Brigade.

a. Mission. The mission of the medical brigade is to:

(1) Provide medical service to the field army through the command and control of the operating units of the field army medical service system.

(2) Develop, refine, and implement medical plans.

(3) Control, direct, and integrate medical service operations.

(4) Reinforce the medical service of the Army divisions.

(5) Perform the overall medical service mission to include area medical service. This includes the functions of patient evacuation; care and treatment; medical supply and maintenance; and dental, veterinary, preventive medicine, and laboratory services.

b. Organization for a 12 division force. (See Figure A-I-1). The medical brigade consists of a headquarters and headquarters detachment, a number of medical groups and medical battalion headquarters, and the medical service operating units of the field army. A personnel services company is attached to furnish services for all personnel of the medical brigade and attached units. The medical brigade may be tailored to the field army mission. Flexibility of organization is inherent and permits rapid organizational adjustment to changing medical service support requirements.

c. Concept of operations. The medical brigade is a major unit of the FASCOM and the medical brigade commander reports directly to the FASCOM commander. Under the direction of the brigade commander, three medical groups, including attached evacuation, hospitalization, and area medical service units, normally operate in the forward areas in support of the combat corps and divisions. One medical group with evacuation, hospitalization, convalescent, medical laboratory, preventive medicine, supply, and area medical service units operates to the rear of the three forward groups. The medical battalions of the groups control ground evacuation and area medical services, while the group headquarters normally retains command and control of the air ambulance companies, hospitalization units, and other medical service elements. Usually the groups operate under mission-type orders from the brigade.

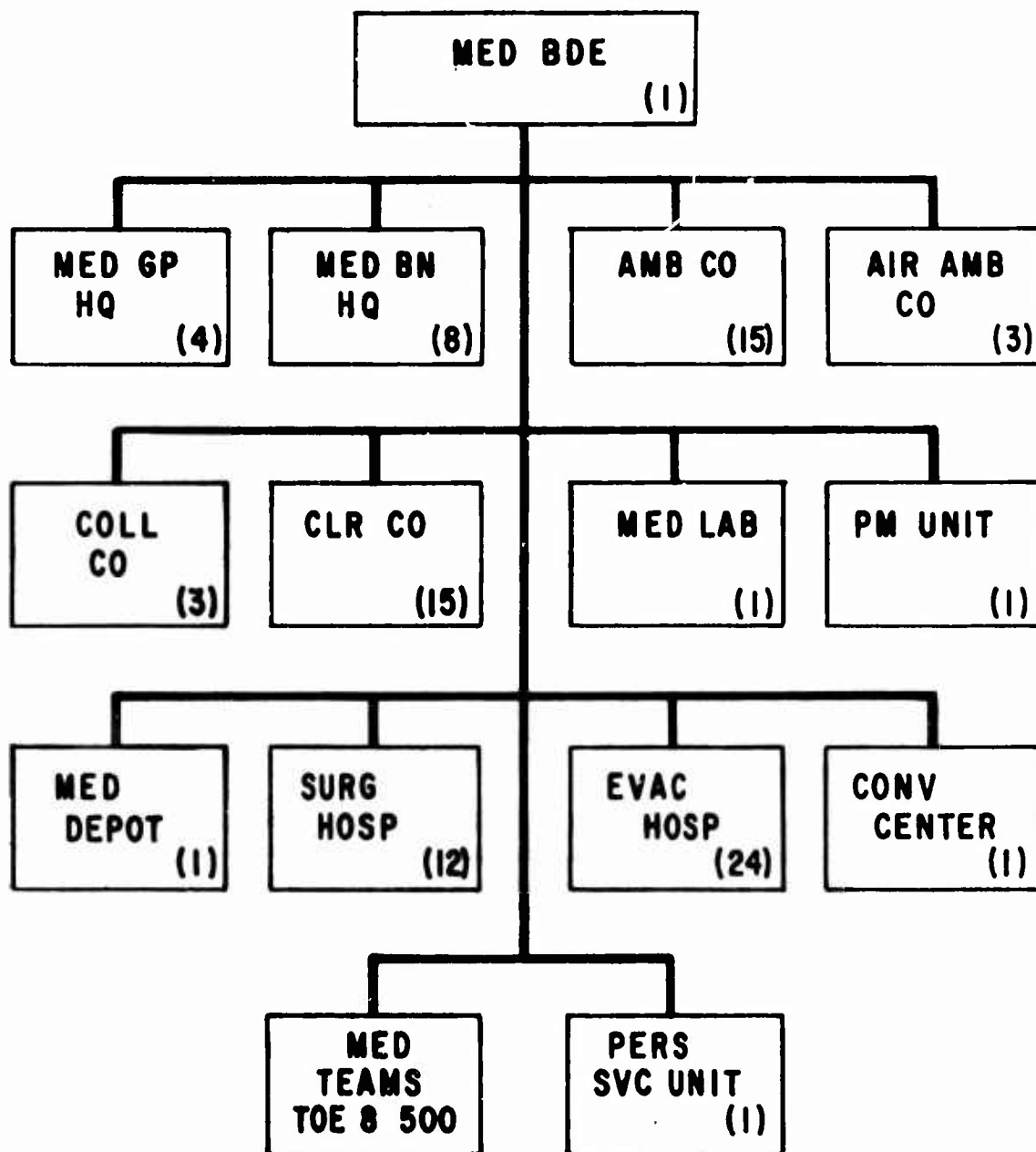


Figure A-I-1. MEDICAL BRIGADE (CO-STAR)

APPENDIX II TO ANNEX A

PROPOSED MEDICAL SERVICE ORGANIZATION AND OPERATIONAL CONCEPTS IN THE FASCOM

1. Purpose. The purpose of this appendix is to present and discuss the proposed medical service system to include organization, operational concepts, operating procedures, and other data to illustrate how medical support will be provided to the field army under the TASTA-70 concept.

2. The Medical Brigade.

a. The proposed medical brigade organization and mission will differ only slightly from the current CO-STAR organization (see paragraph 2, Appendix I to Annex A). The organizational structure for a 12 division force has been changed by adding three command and control units which were necessary to permit improved span of control. The concept of operations remains unchanged except for the introduction of automatic data processing systems which will facilitate medical operations within the field army. Mission responsibilities for medical supply and maintenance are vested in the medical brigade. Medical stock control and inventory control will be accomplished by the Army Medical Depot.

b. Mission. To furnish, through subordinate units, continuous definitive type hospitalization; evacuation; reinforcement; and dental, veterinary, laboratory, preventive medicine, and medical supply and maintenance service to the field army.

c. Organization for a 12 division force. (See Figure A-II-1). The medical brigade is a functionally oriented organization and is a major subordinate element of the FASCOM. The medical brigade consists of a headquarters and headquarters detachment; a number of medical groups, battalions, hospitals, evacuation units; a preventive medicine service unit; a convalescent center; a medical laboratory; an army medical depot; and TOE 8-500 cellular teams. Medical means are provided which allow centralized control with decentralized execution of the medical service mission.

d. Concept of operations.

(1) Command and control.

(a) The field army medical brigade headquarters provides command, control, planning, and continuous operation of the field army medical service. Execution of the medical service mission is accomplished through centralized control of decentralized operations. Policies are provided for the effective integration of medical activities in the field army and are coordinated with supported units.

(b) The major subordinate command and control elements of the medical brigade consist of three forward and three rear medical group headquarters. The number of units attached to these groups may vary according to the requirements of the tactical situation and specific missions assigned.

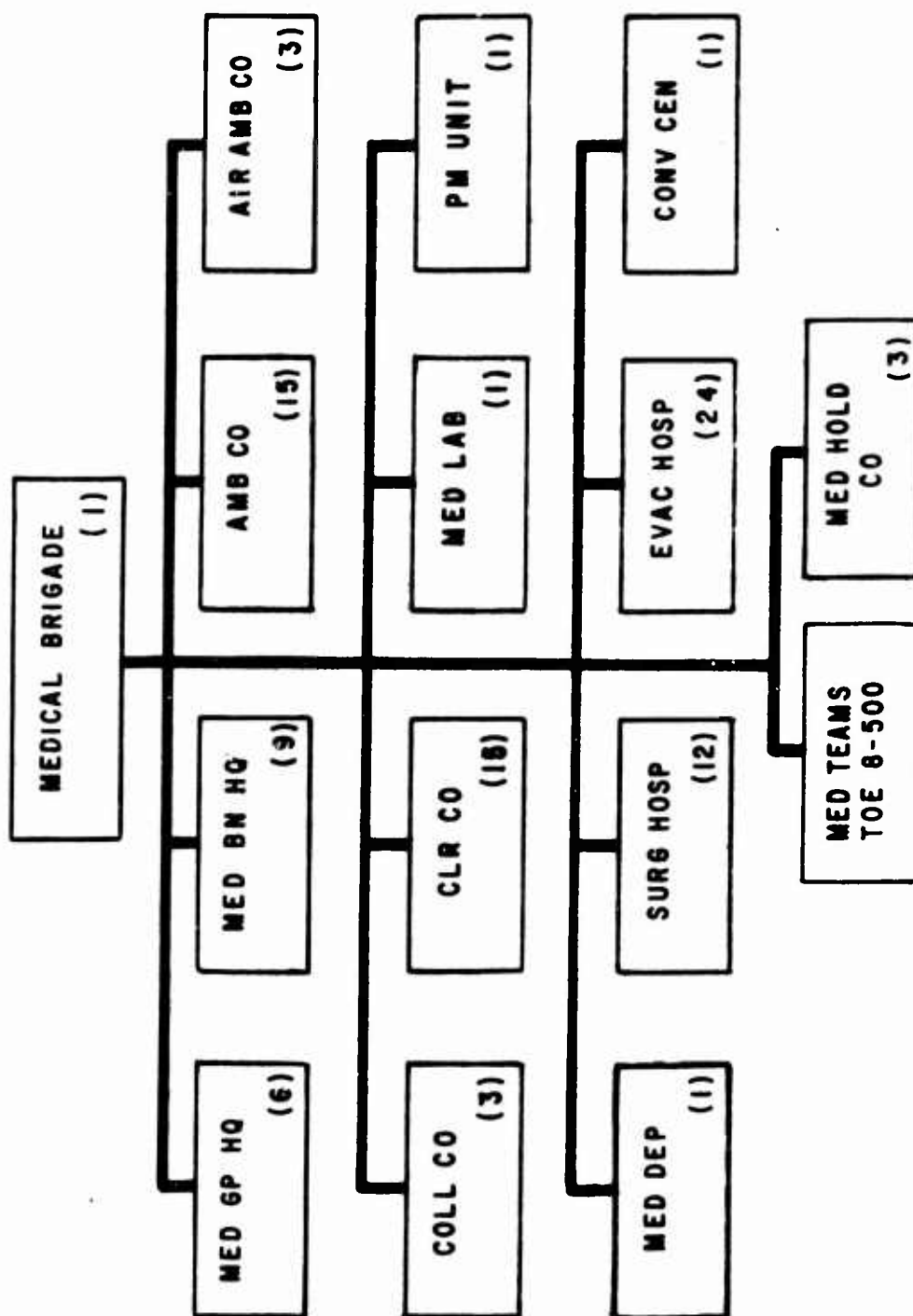


FIGURE A-II-1. MEDICAL BRIGADE (TASTA)

(c) The forward medical groups are concerned primarily with the evacuation and treatment of patients received from divisions. The rear medical groups are designed to provide a continuous hospital service for the field army. These groups will operate as close as possible to the combat units without interfering with combat operations. In addition, all medical groups furnish medical service support on an area basis, as required.

(2) Hospitalization.

(a) The evacuation hospital, 400-bed, is the primary unit providing hospitalization to field army troops. It provides hospital care for all classes of patients and definitive care for those patients who can be returned to duty within the prescribed evacuation policy of the field army. In field army, the evacuation policy is very fluid, varying from hour to hour and day to day in accordance with the tactical situation, manpower policies, admission rates, and available beds. For other patients, it will provide the treatment necessary to prepare them for evacuation to the general hospitals of the communications zone. The flow of patients from divisions, as well as from nondivisional units, into evacuation hospitals will be controlled in such a manner that a patient will be admitted to the hospital most capable of providing the care required at the time needed. The hospital's capability is predicated primarily on the surgical backlog and the beds available at any given time. Thus, patients from one division may well be distributed to two or more evacuation hospitals. This control of the flow of patients into hospitals is known as medical regulating.

(b) The other type of hospital allocated to the field army is the mobile army surgical hospital--a specialized hospital not normally in the evacuation chain. It is designed to provide resuscitative surgery and medical treatment for critically injured or ill patients whose lives or limbs would be endangered by the delay inherent in moving them further to the rear to evacuation hospitals. This hospital is 100 percent mobile with organic transportation to permit it to retain close proximity to the division it is supporting. One surgical hospital will support each committed division. This does not preclude admitting patients received from other divisions. The flow of patients into surgical hospitals is controlled in the same manner as discussed above for the evacuation hospital.

(3) Evacuation.

(a) Field army medical service is responsible for evacuating patients from division clearing stations to the hospitals of the field army. Transportation is by ground and air ambulances.

(b) Ground ambulance companies are responsible for routinely evacuating patients from division and nondivisional clearing stations to the appropriate field army hospital. Patients evacuated from divisions by ground ambulances will flow into supporting hospital facilities over relatively fixed routes.

(c) Air ambulance companies and detachments are responsible for evacuating all categories of patients to designated field army hospital facilities. Normally, medical air ambulances will be used on an "on call" basis. Priority will, in all cases, be given to the seriously wounded. When available and circumstances permit, aeromedical evacuation means will be used more heavily than in the past. Greater flexibility and responsiveness is introduced into the medical evacuation system with increased use of air ambulances.

(4) Medical service to nondivisional troops. Medical service for corps and army troops is provided by the medical brigade on an area basis and includes all medical service support functions.

(5) Medical supply and maintenance.

(a) The army medical depot operates under the command and control of the FASCOM medical brigade. This unit provides medical supply and maintenance services for all units in the field army area. Advance platoons of the depot establish supply points well forward in the corps to provide direct support to division medical battalions, hospitals, and other units in the area.

(b) The medical depot establishes the base platoon in the field army service area. Supply levels of advance platoons will be kept at a minimum to permit their relocation whenever necessary to provide close and timely service to supported units. Division medical battalions submit their supply requirements to the supporting medical supply point. Requirements are forwarded by ambulance, other vehicles, or other available means of communication. Normally, medical supply distribution is through back haul of medical brigade ambulance elements supporting the division. FASCOM medical units and all other nondivisional units obtain medical supply and maintenance services on a direct support basis from the supporting base or advance platoons of the army medical depot. Unfilled and replenishment requirements of advance platoons are transmitted to the FASCOM medical ICP through the CS₃ communications system. Distribution is accomplished by shipment to advance platoons or throughput to using units. Unfilled and replenishment medical supply requirements of the field army are transmitted from the FASCOM medical ICP to the TASCOM medical ICP through the CS₃ communications system. Distribution from TASCOM medical depots is accomplished by shipments to the army medical depot base platoon or by throughput to advance platoons or using units.

(6) Convalescent center. A limited convalescent capability is provided for the field army to permit a more rapid restoration to full duty of those patients who otherwise would be evacuated out of the field army area.

(7) Preventive medicine. A preventive medicine field service unit provides comprehensive preventive medicine support to the field army.

(8) Medical laboratory. A medical laboratory provides complete medical laboratory services for the field army. This unit includes

capabilities for assistance in the identification of nuclear, biological, and chemical agents; medical research; technical inspection; manufacture of diagnostic agents; support of epidemiological studies; and the establishment of a histopathology center.

(9) Dental support to the field army is provided by TOE 8-500 mobile dental treatment teams operating under the command and control of the medical brigade. Hospital dental services are also provided as well as emergency dental service for the divisions by additional Dental Corps officers organic to these organizations.

(10) Veterinary service in the field army includes the control of food borne and zoonotic diseases, treatment hospitalization, and dispensary service for military animals, inspection and supervision relative to food products plus those preventive medicine activities assigned by the responsible surgeon. These services are provided on an area basis by TOE 8-500 teams consisting of veterinary hospital, dispensary, and food inspection teams commanded and controlled by veterinary headquarters teams of the Army Medical Service.

3. See FM 8-16-1 (TEST), Medical Service, Field Army, for description of Army Medical Service units, FASCOM.

ANNEX B

ARMY MEDICAL SERVICE IN THE COMMZ

1. Purpose. This annex will present the general considerations of medical service required for the communications zone under the TASTA-70 concept.

2. General.

a. Introduction.

(1) Medical service in a theater of operations is continuous. It is interzonal and intersectional in character; interzonal in that the efficiency of its operation depends upon the coordination established and maintained between the medical services of the combat and communications zones; and intersectional in that treatment in fixed hospitals and the evacuation of patients cannot be limited to sectional boundaries.

(2) The communications zone is the area required for the administrative support of the theater as a whole. The nature of the administrative operations in comparison with the ground combat operations of the combat zone implies a less active role. However, from the standpoint of the medical service this implication is not based on fact. This is evidenced by the great mass of work of the medical service in the communications zone resulting from the rearward movement of patients from the combat zone.

b. Missions of COMMZ medical service.

(1) Relieve the combat zone of its patients. The combat zone must be relieved of its patients in such a manner that the hospitalization units of the combat zone may retain their mobility, thereby retaining close proximity to the forward moving troops of the combat zone. Another important function is that of reinforcing the medical service of the combat zone when required.

(2) Medical support to COMMZ troops. Medical support must be provided to Army troops located in or passing through the communications zone.

(3) Medical support to PW's and other personnel in COMMZ. This mission involves providing medical support to prisoners of war and other personnel as directed by competent authority. In a large land mass theater, additional missions for the communications zone could include the provision of medical support not only to Army troops but also to U S military personnel of other services, U S merchant seamen, civilian employees of other U S government agencies, allied nationals, and indigenous personnel employed by U S military forces.

c. Major functions of the COMMZ medical service. The major functions of the COMMZ medical service are essentially the same as those performed by the field army medical service. They differ only in degree and the magnitude of work to be accomplished. Treatment of patients is one of the major tasks involved. It also is one that provides the greatest workload for the medical service. Hospitalization in the communications zone is different from that of the field army medical service in that reparative and definitive type treatment is available for all classes of patients on a relatively long-term basis. The great bulk of the patients provided hospitalization in the communications zone will come from the combat zone. There is also a requirement for area hospitalization service and dispensary type care for troops in the communications zone. Dental care is also a part of the treatment provided by communications zone Army Medical Service. Treatment is definitive and differs only from the combat zone service in that the dental clinics and prosthetics laboratories are relatively fixed as distinguished from the mobile units employed in the combat zone. Another major task requiring considerable medical resources concerns the evacuation of patients from the combat zone into hospitals located in the communications zone. Other major functions include preventive medicine, laboratory service, veterinary service, optical repair, distribution of whole blood, and medical supply and maintenance.

(1) Hospitalization.

(a) The theater army COMMZ provides hospitalization for all patients originating in the communications zone and those received from the combat zone. The number and types of hospitals depend upon the location of the communications zone in relation to the zone of interior, the extent of the zone, troop strength of the theater, the nature of military operations, the character of hostile resistance, and the theater evacuation policy. Hospitals of the combat zone are characterized by their mobility; those of the COMMZ by their immobility. In the combat zone, mobile and semimobile hospitals can be established in a matter of hours; they can be established under tentage or other shelter without impairment of their functions; they can be prepared for movement in several hours after evacuation of all patients; they can be transported to a new location rapidly; and they possess the flexibility inherent in semimobile and mobile units. In absolute contrast, general and station hospitals in the COMMZ, except when located in existing hospital plants, require many weeks for plant development to the stage where they can function normally. They are dependent upon the availability of engineer technical assistance, labor, and supplies. They require extensive and proper shelter and utilities. After once having been established, preparation for movement after all patients have been evacuated can only be executed with great difficulty, time-consuming effort, and a major loss of fixed bed potential. General and station hospitals normally are employed in the more secure areas of the COMMZ and once established, the only possible flexibility existing in these fixed hospitals is measured by the number of expansion beds that are provided over and above its rated patient capacity. After development has once been started on a fixed bed installation, it is undesirable to change its location because of the time and expense involved unless major tactical, strategic, or logistical conditions dictate a change of location.

(b) Field army hospitals can be established without appreciable time lag provided personnel, equipment, and transportation are readily available. In the communications zone, however, the extensive time lag existing between planned fixed beds and fixed beds ready for occupancy by patients requires long-range planning based on the best information available regarding the strategic, tactical, and logistical plans of the theater. Delay in the implementation of the fixed hospitalization program until the location of hospitals is ideal will increase the time lag necessary to develop such hospitals and will not provide the fixed beds required at the time needed.

(c) Normally, field army hospitals are not concerned with construction standards, except as they may be affected by the need for winterization, insect proofing, and protection from excess heat. However, in the construction of fixed hospitals, it is necessary to develop long-range design and construction standards and, in cooperation with the engineers, to provide shelter and utilities. The supplies necessary for the construction of hospital plants are provided by the engineers. At times, it may be possible to locate fixed hospitals in existing hospital plants, if such plants are of sufficient size; to enlarge existing hospital plants; to provide shelter under tentage; to construct prefabricated buildings; or to utilize a combination of these methods. The principle to be followed is that the most adequate shelter for the purpose will be made available for hospitalization.

(d) Field army hospitals preserve their mobility by transfer of patients to hospitals in the communications zone. Since hospitals in the COMMZ are the rear termini of the evacuation system in the theater, they must be able to absorb a large volume of patients and, either by return to duty or evacuation to the zone of interior, reduce their patient load. The only reserve provided is by means of expansion beds which is an emergency measure.

(e) Types of hospitals. Hospitals in the COMMZ are classified and organized on the basis of bed capacity, type, and extent of medical care performed and mission responsibility.

1. General hospital. General hospitals are fixed installations designed to provide hospitalization of a definitive nature for all types of patients in a theater of operations. General hospitals receive patients from field army hospitals, COMMZ, station and field hospitals, and by direct admission. Normally, the majority of their patients come from the combat zone.

2. Station hospital. Station hospitals are fixed hospitals which normally serve a limited area to which assigned and routinely do not receive patients from the combat zone. They are organized and classified according to their patient capacity and are established at locations in the communications zone where there is sufficient concentration of military personnel to require local

hospitalization. In the establishment of station hospitals, the same general problems arise as in the establishment of general hospitals.

3. Field hospital. Field hospitals are organized and designed to provide hospitalization facilities for 400 patients in areas of temporary troop concentrations and to establish and operate medical holding installations. In some cases they may be utilized to supplement general hospitals in order to temporarily provide hospitalization while construction for the general hospital is under way. The field hospital may be divided into three 100-bed hospitalization units, each of which is capable of separate, independent operations for a limited period of time.

4. Convalescent center. Convalescent centers in the COMMZ are classed as fixed installations. However, regardless of where units of this type are employed, they are not charged to the theater as fixed beds. Normally, these units are adjuncts to fixed hospitals and are not capable of providing definitive treatment comparable to that afforded by hospitals. The convalescent center in the COMMZ has a normal rated capacity of 1500 patients and may be augmented to provide facilities for an additional 1500 patients. This center provides facilities where patients may convalesce and receive reconditioning training prior to return to duty. It receives patients from other hospitals within the theater of operations who do not need further hospital treatment but who require further reconditioning under medical supervision prior to return to a duty status.

(f) Holding units. There is a requirement for facilities for the care and treatment of patients at each location where there is a major change in the mode of evacuation. At railheads, patients must be collected and held ready for the arrival of ambulance trains which continue evacuation. To attempt to move the number of patients required to fill an ambulance train at one time from scattered medical units to the entraining point requires an unnecessarily large number of ambulances, disrupts the normal operations of medical units, and frequently results in hardship for the patients while being held in ambulances awaiting the arrival of the ambulance train. The same considerations hold for airheads and ports of embarkation and debarkation. At the rear termini of air, rail, and water evacuation, means are required for the reception and distribution of large numbers of patients to the appropriate hospital facilities. When the route of evacuation extends over long distances, it may be necessary to establish intermediate installations to provide rest for the patients while in transit. These installations are known as holding units and their primary function is to provide temporary shelter and emergency medical treatment for patients while they are awaiting transfer. Units used to perform such missions include field hospitals, medical clearing companies, medical holding companies, and even general hospitals, when necessary.

(g) Hospital centers. When practicable, hospital centers are formed by grouping two or more general hospitals under a

hospital center headquarters. This unit provides a command and administrative agency to affect a consolidation of functions and to insure the maximum utilization of available medical service personnel and facilities. Through centralized control the hospital center correlates and coordinates the activities of attached hospitals. Certain hospitals operating under the hospital center may be staffed and equipped to provide specialized treatment. Thus, the operating hospital center affords the opportunity for increased specialization in the field of medicine indicated. This procedure provides the additional advantage of fully utilizing the skills of highly qualified professional personnel.

(2) Evacuation.

(a) Evacuation is one of the major tasks of the COMMZ medical service. Prompt and efficient evacuation is necessary in the theater of operations in order to prevent the adverse effect of unevacuated casualties on combat efficiency and to distribute sick and injured in available hospitals where they can receive the highest standards of medical care. Since it is fundamental principle of the medical service to evacuate patients no farther to the rear than their condition or the military situation warrants, provision must be made throughout the evacuation system for sorting (triage). Normally, sorting takes place at each installation where there is a change in the means of transportation or where responsibility for evacuation is transferred. The decision to retain or evacuate patients is based on professional and military considerations. Evacuation and hospitalization are twin considerations, and each depends upon the other for ultimate efficiency.

1. The availability of sufficient transportation by ship, aircraft, train, or vehicle determines the extent and degree to which evacuation can be carried on. However, whenever the situation permits, first consideration will be given to evacuation by air. Except for ambulances, the medical service controls no other transportation means for evacuation from the combat zone to the communications zone, and controls no transportation means for evacuation from the communications zone to the zone of interior. For additional means of evacuation, the medical service is dependent upon the particular service (Air Force or Navy) controlling aircraft and ships, or the command controlling trains or other forms of transportation. The requirement for land, rail, air, and water evacuation means must, therefore, be continuously forecast so that coordination for their procurement may be made sufficiently in advance of needs. Since maximum use must be made of transportation, sufficient manpower and ambulances are required within a minimum period of time for the transfer of patients from one type of transportation to another, and from such transportation to hospitals.

2. In the combat zone, evacuation involves the movement of patients by ground and/or air ambulance in a fairly continuous flow directly to hospitals, while, in the COMMZ, patients are moved intermittently by train, plane, ship, and vehicles. In the communications zone, patients are delivered to airfields and railheads located in the vicinity of hospital sites. For this purpose, sufficient numbers of litter bearers and ambulances are required to unload and transport peak

loads of patients expeditiously. The number of litter bearers and ambulances required is dependent upon number of patients to be moved and the distances involved. When relatively few patients arrive and distances are not too great, general hospitals may be able to complete this transfer of patients with their organic means. However, evacuation between hospitals of the communications zone and to ports or airfields by trains, planes, or ships, entails peak patient loads and requires additional litter bearer and ambulance elements. The location of field army hospitals in the combat zone has relatively little effect on the pattern of evacuation in that zone, while hospitals in the communications zone, when once established, fix the evacuation pattern. General hospitals established without regard to rail or air service will continue to jeopardize efficient evacuation as long as they are in operation. Although in many cases the need for fixed beds cannot always be delayed to await the determination of ideal evacuation patterns, general hospitals must be located, so far as practicable, with due regard to this factor.

(b) Evacuation from combat zone to communications zone. Normally, no level of medical service is responsible for the evacuation of patients beyond its rearmost medical installation. In the case of field army medical service, the rearmost unit may be either an evacuation hospital or a holding unit. It is a general principle that holding installations in the combat zone are initially established and operated by field armies in the vicinity of railheads and airfields utilized for patient evacuation. During the time holding units are established and maintained by the field army, they are considered medical installations of the field army and operate under the control of the field army commander. On the other hand, when responsibilities for holding units at a particular site have been taken over by the COMMZ medical service, it is considered to be an installation of the COMMZ medical service and is so operated and controlled. It is therefore necessary that units be made available in both the combat and COMMZ for the establishment of holding installations capable of properly performing this function.

1. All means of surface transportation may be employed in evacuation from the combat zone to the COMMZ depending upon the geography of the theater. Where distances are great and railways are available, they constitute the most efficient means of surface transportation. Ambulance trains are allocated to the COMMZ medical service, and their movement is controlled by the Movement Control Center (MCC).

2. Air evacuation in the theater of operations is the responsibility of the theater commander. The Theater Air Force Surgeon provides guidance as to the types of patients to be evacuated by air. The Theater Air Force Commander provides the necessary aircraft for patient evacuation as well as the medical personnel and equipment needed to provide in-flight treatment. Whenever possible, patients are delivered to airfields convenient to fixed hospitals. When required to land at emergency airfields where there are no provisions for the reception of patients, temporary medical treatment is normally provided by the Air Force from local resources. The field army surgeon and the COMMZ surgeon are responsible for the selection of patients to be evacuated by air from

medical installations under their control.

(3) Medical supply and maintenance.

(a) The theater army commander is responsible for the development of supply systems which will insure adequate provision of supplies for theater army forces and, when applicable, for Navy, Air Force, and civil affairs activities. The development of a medical supply system depends on conditions existing in the particular theater; for example, the system developed on a large land mass will differ from that required in ocean areas where islands and island groups are separated by great distances. The availability of shipping and the adequacy of harbor discharge facilities are other factors which influence the storage and distribution of supplies to the theater and to using agencies, and materially affect the development of a medical supply system.

(b) The determination of the number, type, location and mission of medical supply installations to be established in the COMMZ is generally dependent upon the number of troops to be served, their locations, and the availability of means for the storage and distribution of supplies by rail, water, highway, and air. Medical supply installations in the COMMZ are operated by TOE units augmented, whenever possible, by local labor and by prisoner of war labor.

(c) The distribution of medical supplies and equipment is controlled by the medical command. A stock control system is established to maintain adequate stocks of supplies and equipment in the supply system. Medical supply units submit, at designated intervals, reports which reflect their stock position. Based on the reports, transfers between medical supply elements are directed by the medical command commander, and periodic requisitions are submitted through established theater channels to CONUS to maintain theater supply levels. Local purchases of medical supplies in the theater of operations are desirable, wherever practicable, in order to save time and shipping space. However, any plan for local purchase must be carefully considered from the following standpoints:

1. The acceptability of foreign-produced materiel.
2. The effect on medical proficiency standards resulting from the use of equipment which requires special training to operate.
3. Difficulties in the procurement of repair parts and replacement items.
4. Problems of operating a medical supply system involving a large number of foreign-produced nonstandard items.
5. The possible effect of disrupting existing controls on civilian economy.

6. The time necessary for the production and delivery of foreign-produced equipment.

(d) Medical units submit requisitions directly to designated medical supply elements. Requisitions for regulated items (designated items requiring approval of higher headquarters), and for items in excess of authorized allowances, are submitted to the Medical Command Commander.

(e) The Army is responsible for providing medical care and treatment for all prisoners of war and civilian internees. In computing requirements for supplies and equipment needed to perform this function, full use should be made of all available intelligence data pertaining to the incidence of disease among enemy forces and estimates of the numbers of such individuals for whom medical care must be provided. It is possible that the number of prisoners of war and civilian internees will be such as to require the establishment and equipment of special hospitals for this purpose. When authorized, medical supplies and equipment captured from the enemy are utilized by combat units or turned over to designated medical supply depots. Captured supplies and equipment are of value in the treatment of prisoners of war, since captured medical personnel are familiar with such equipment. It is essential that adequate samples of all captured medical items be preserved and turned over to technical intelligence elements for inspection and testing.

(4) Veterinary service. Veterinary service in the COMMZ includes the control of food borne and zoonotic diseases; treatment, hospitalization, and dispensary service for military animals; inspection and supervision relative to food products; and those preventive activities assigned by the responsible surgeon. These services are provided on an area basis by TOE 8-500 teams consisting of veterinary hospital, dispensary, and food inspection units commanded and controlled by veterinary headquarters elements of the Army Medical Service.

(5) Dental service.

(a) In the COMMZ, Dental Surgeons are assigned as staff officers to the medical command headquarters of Hospital Center Headquarters and Headquarters Dental Professional Service. The latter unit is normally attached to subordinate medical headquarters and provides command and control of attached dental service units.

(b) General doctrines:

1. Commanders are responsible for the provision of dental service for all military personnel of their commands and such other persons designated by the command or by higher headquarters.

2. Dental service should be so organized and deployed to provide optimum service with the least inconvenience to the units supported.

3. Emergency dental treatment must be available to all troops at all times.

4. Routine dental care must be available at all times when the tactical situation permits.

5. Continuous preventive dentistry support must be available at all times to maintain the dental health of the command.

(c) TOE dental units are under the command of the major medical headquarters to which assigned. Operational control of such units is normally a function of the command dental surgeon. The dental surgeon designates mission and allocates resources for dental support of the command. Control remains centralized, but operations are decentralized, and becomes the responsibility of dental unit commanders.

(6) Whole blood requirements.

(a) Blood loss from a patient with a resultant decrease in the circulating blood volume, is the most important cause of shock in battle casualties. Whatever the contributory cause, the underlying cause of shock in most cases is blood loss. The regimen of resuscitation is a complex affair, but the principal means is the administration of whole blood. Whole blood has a relatively short shelf life (approximately 21 days). The collection of whole blood involves many personnel and once collected it must be inspected and typed. Whole blood requires special handling and storage facilities to include close temperature control within specified limits. Special requirements in transportation are necessary to insure that whole blood arrives at its destination on a timely basis and in satisfactory condition.

(b) Collection of whole blood from troops on the line should be avoided because of the adverse effects a loss of blood would have upon combat troops. Consequently, the collection of whole blood within the theater of operations should be from service support troops with the greatest volume coming from COMMZ troops. Heavy requirements for whole blood will exist both in the COMMZ and in the field army. Consequently, the plan to provide whole blood for a theater of operations should be based on the concept that the handling and use of whole blood and other replacement fluids is a specialized procedure and that to collect blood, to group it correctly, and to transport and preserve it safely requires the services of specially trained personnel. These functions cannot be delegated to untrained personnel because any slip, however trivial, in the collection, processing, and use of whole blood may result in severe and even fatal reactions.

d. Medical management procedure and systems. Planning for and the evaluation of factors concerning medical care for the wounded in modern warfare requires a broad background of factual information, much of it statistical in nature. Past experience indicates a requirement exists to develop improved methods of collecting medical data in order to provide a more definitive matrix of factual data in forecasting the needs of the medical service.

the needs of the medical service.

(1) Patient accounting. A procedure which provides for the accounting of patients in the hospitalization and evacuation system.

(2) Medical reports and statistics. Medical reports are procedures designed to extract certain information from the patients' health and clinical records by the attending medical facilities and the subsequent summarizations of this information into statistical data.

(3) Medical regulating is covered in detail in Appendix I and Appendix II, Annex B.

(4) ADPS. The use of ADPS for medical service operations involves collection, dissemination, collation, summarizations, and analysis of medical data of a statistical nature to facilitate decision making processes and to provide adequate quantitative and qualitative historical data. (See Annex F, ADPS Implementation.)

3. Current Medical Service Organization and Operations in the COMMZ.
(See Appendix I to Annex B.)

4. Proposed Medical Service Organization and Operations Concepts in the TASCOR. (See Appendix II to Annex B.)

APPENDIX I TO ANNEX B

CURRENT MEDICAL SERVICE ORGANIZATION AND OPERATIONS IN THE COMMZ

1. Purpose. The purpose of this appendix is to illustrate the current medical service organization for the COMMZ.

2. General.

a. The theater of operations is normally divided into a combat zone and a COMMZ, the COMMZ being organized for the administrative support of the theater as a whole. Depending on its size, the COMMZ may be divided only to the degree necessary to carry out its mission. The organization is keyed to the plan of operation and is based on conditions in the theater. The territorial organization of COMMZ might include advance sections, base sections, and area commands.

b. The theater army logistical command (TALOG) is responsible for operations in the COMMZ. When circumstances dictate a divided COMMZ, the TALOG commander assigns territorial responsibilities to subordinate commands. Advance logistical commands (ADLOG) exercise control over the advance sections; the base logistical commands (BALOG) exercise control in the base sections; and designated area commands exercise control over the subareas.

c. Logistical command headquarters are of three types--Type A, Type B, or Type C and are organizations which provide the command and staff nucleus for command and control over the various territorial divisions of the COMMZ. Each logistical command must be augmented and tailored to meet the task at hand.

3. COMMZ Medical Service.

a. Mission. The mission of the COMMZ medical service is to provide medical support to the combat zone as well as to Army forces located in the COMMZ and to elements of other services, when required.

b. Organization. The medical organization of the TALOG is subject to extreme variation depending upon its size and location, nature of the operation, and the desires of the TALOG commander. There are, however, certain principal elements present--the TALOG surgeon, hospitalization, evacuation and other supporting medical units and detachments.

c. Concepts of operation.

(1) The TALOG surgeon, as a special staff officer to the TALOG commander, supervises the medical activities of the entire COMMZ. When no sections of COMMZ are established, operational control of major medical units and installations is vested in the TALOG surgeon. In this instance, the TALOG surgeon is an operator as well as a planner and supervisor. When COMMZ sections are established, many of the detailed operations of the medical service are decentralized to the section

commanders. Under these conditions, the TALOG surgeon may become primarily a planner and a policymaker, while the section commanders through their surgeons operate the principal medical units and installations of the COMMZ. Decentralization of medical functions to the section commanders is limited, however, to those activities which do not interfere with the operation of the COMMZ medical service as a whole. The TALOG commander, therefore, normally retains control of such activities as site selection for hospitals, construction standards, and medical regulating activities concerning the movement of large numbers of patients from the combat zone and between sections of COMMZ. There is no established organization for the office of the TALOG surgeon, but the size and composition of the section is determined on the basis of mission and functions to be performed.

(2) Hospitalization.

(a) The TALOG provides hospitalization for all patients originating in the COMMZ and for those received from the combat zone. The number and type hospitals depends on the location of the COMMZ in relationship to the zone of interior, the troop strength supported, the nature of the operation, the character of hostilities, and the stated evacuation policy. COMMZ hospitals differ from those found in the combat zone since they are relatively immobile, require construction which takes a great amount of time, and handle a larger volume of patients. These hospitals are classified and organized on the basis of bed capacity, mission, and type or extent of medical care performed.

(b) The numbered general hospital is a 1,000-bed facility designed to provide hospitalization of a definitive and specialized nature. These hospitals receive patients from the combat zone and from other hospitals located in COMMZ. The general hospital is in the normal system of evacuation and receives most of the patients that come from the combat zone. Station hospitals varying in size from 100 to 750 bed capacity provide hospitalization to troop concentrations in the COMMZ and are really not unlike those found on any post, camp, or station in the CONUS, except for the physical plant occupied. These hospitals do not routinely receive patients from the combat zone. One other unit, the field hospital, is organized and designed to provide hospitalization for temporary troop concentrations in the COMMZ. This hospital has a degree of mobility and flexibility and is designed to operate either as a single 400-bed facility or it may establish three separate hospitalization units of 100 beds each. This hospital is not in the normal system of evacuation, since it does not ordinarily receive patients from the combat zone.

(3) Hospital center headquarters. The hospital center headquarters is a command element which exercises control over two or more general hospitals to effect efficiency of operations and to permit efficient use of specialized professional skills. The hospital center serves to reduce the span of control of the TALOG surgeon or the BALOG surgeon should general hospitals be decentralized to BALOG control.

(4) Evacuation. Evacuation units found in the COMMZ are for the most part identical to those which perform the evacuation role in the combat zone. Army ground ambulance units are located throughout the COMMZ to provide evacuation means to COMMZ troops on an area basis. The principal army medical evacuation means from the combat zone to the COMMZ is the ambulance train, rail. The bulk of the patients from the combat zone are evacuated to the COMMZ by the theater Air Force.

(5) Medical regulating. Medical regulating is the operating procedure that coordinates and facilitates the patient treatment and evacuation. It is a system within the overall sphere of field medical operations designed to ensure the efficient and safe movement of patients, often over great distances. In addition to identifying the patients awaiting evacuation and the available beds, transportation means are coordinated so that each patient is moved to the proper treatment facility on a timely basis. On a daily basis, field army hospitals determine the number of patients who will not be returned to duty within the prescribed evacuation policy and who can withstand transportation to the COMMZ. A similar determination is made by COMMZ station hospitals. Also, on a daily basis, general hospitals within the COMMZ report the number of vacant beds in their installations. All the information indicated is submitted through appropriate channels to the TALOG medical regulating officer who decides on the distribution of the incoming patients to the general hospitals. Following this, the transportation means are coordinated which permits the medical regulating officer (MRO) to schedule the patients to be evacuated. Patient evacuation instructions are forwarded on a timely basis to all agencies concerned as to the detailed movement schedule. When the Army Medical Service delivers patients to Air Force casualty staging facilities, the Air Force assumes control of the patients until such time as they are off-loaded at the destination airfield. On arrival at the destination airfield, the patients are again returned to Army Medical Service control. At destination airfields, sorting teams from the hospital center classify and direct the movement of patients to designated general hospitals within the center. Normally needed transportation is provided by pooling vehicles of units within the hospital center. When patients are evacuated from the combat zone by ambulance trains, the Army Medical Service retains responsibility for these patients throughout the evacuation process. Many of the patients evacuated to and within the COMMZ will be treated and returned to duty within the theater. Others, however, cannot be returned to duty and must be further evacuated to the ZI. The theater joint medical regulating officer (JMRO) is contacted by the TALOG medical regulating officer and given pertinent information regarding the numbers and locations of patients requiring further evacuation to the CONUS. The JMRO is in daily contact with the Armed Services medical regulating officer in CONUS and coordination is effected for the evacuation of patients out of the theater.

(6) Area medical service. In the COMMZ, as in the field army, primary medical care for units having no organic medical personnel is provided on an area basis. When normal medical support units are unable to provide this support, medical teams especially organized and trained for special functions are utilized. These teams may be attached or

assigned, as required, to fixed strength units or may be organized into composite units to perform their specific missions under varying conditions. These units are organized under TOE 8-500 and their capabilities vary with the size and grouping of the teams used.

(7) Medical supply.

(a) Two major units provide medical supply support in a theater of operations--the medical depot (COMMZ) and the army medical depot. Cellular teams (TOE 8-500) providing medical supply, optical, and medical equipment maintenance services may be utilized to augment depot capabilities. COMMZ medical depots require the assistance of laborers from indigenous or other sources.

(b) At ports of debarkation, medical supplies are unloaded, segregated, and forwarded to designated COMMZ medical depots. The depot system in a COMMZ is a flexible organization. Normally, a depot is established in the base section of the COMMZ to where the majority of the items are forwarded from the port. The medical depot (COMMZ) serves as a bulk storage plant for the theater. Medical depots (COMMZ) have the mission of supporting local units in addition to supporting the combat zone.

(c) The medical depot (COMMZ) may serve as a receiving depot at a port, as a distribution depot in the COMMZ, or as a filler depot in the advance section of a COMMZ. It provides, in addition to medical supply support, depot medical maintenance for COMMZ medical units and backup depot maintenance support for the army medical depot. The optical shop fabricates and repairs spectacles and the blood distribution section distributes whole blood to hospitals in the COMMZ on a daily basis. Whenever possible, the transport of whole blood is made by air.

(d) The flow of medical supplies within a theater of operations is as follows:

1. Division. The headquarters and support company of the medical battalion has a division medical supply and battalion support section. This section is also responsible for medical supply support for the entire division. The S4 of the medical battalion is responsible for the division medical supply function. The division medical supply point carries a two-day (normally) supply of fast-moving items. Division medical supply points are replenished from medical supply installations in the corps or army area.

2. Field army. The army medical depot services the field army and supports the divisions through the division medical supply point. The army medical depot consists of a base platoon and three advance platoons and is allocated on the basis of one per field army. The base platoon of the army medical depots consists of an issue and storage section, a blood distribution section, a general maintenance section, and an optical section. The base platoon will normally carry five to seven day stockage for the field army. The blood distribution section, as is also the case with the medical depot (COMMZ), is equipped with $2\frac{1}{2}$ -ton trucks and trailers, on which are mounted generators and blood refrigerators.

The mission of the blood distribution section is to effect unit distribution of whole blood to consuming activities. Whenever possible and feasible, the transport of whole blood within the field army will be accomplished by air transport. The general maintenance section provides field maintenance of medical equipment for medical units in their locale plus backup support for the advance platoons employed. The optical section fabricates and repairs spectacles for the field army. The advance platoon consists of a storage and issue section, an optical team, and a medical equipment repair team. Each advance platoon is capable of supporting a corps. Normally, the advance platoon will carry three-days stockage for the troops supported. This three-day stockage at the advance platoon does not count against the theater level.

3. CC.MZ. The medical depot (COMMZ) provides support to the field army based on requisitions submitted from the base platoon of the army medical depot. The medical depot (COMMZ) has four main supply tasks--requirements, requisitioning and procurement, storage, and distribution. The great increase in scope of supply operations in the COMMZ over that of the combat zone is due to two factors. The first is volume. The COMMZ medical depot (COMMZ) must not only be prepared to meet the demands of one or more field armies and of army units within COMMZ, but it must also meet the supply demands of other services, allies, and civilians as directed by higher authority. The second factor is the necessity for long-range planning. While the medical depot (COMMZ) must be prepared to meet supply demands of field armies and other users within a few days, it cannot expect to receive supplies from its principal replenishment source, the zone of interior, on the same basis. Accurate forecasts of requirements as well as efficient supply control and timely requisitioning procedures will insure the ready availability of medical supplies needed to support theater forces.

(8) Dental service. Dental service teams, TOE 8-500, furnish all dental care except for that provided by dental service personnel organic to hospitals, convalescent centers, and certain medical dispensaries. Dental teams operate on an area basis in either GS, DS, or reinforcing-type missions. The teams function under the operational control of the staff dental surgeon of the command to which they are attached or assigned. To insure flexibility and economy in use of available units, control remains centralized, but the operations are decentralized. When attached to subordinate commands, dental unit commanders also function in the capacity of a staff dental surgeon if an organic staff dental surgeon is not authorized. Complete and definitive dental treatment is provided in the COMMZ. There are three types of dental units available to furnish support:

- (a) Dental Operating Detachment, Team KI.
- (b) Dental Service Detachment, Team KJ.
- (c) Dental Prosthetic Detachment, Team KK.

(9) Veterinary service.

(a) Food inspection. The major quantity of subsistence utilized in the theater of operations will be received through ports and over the beaches. Therefore, these locations are the initial inspection points for subsistence received in the theater. Veterinary food inspection at ports of entry is designed to prevent subsistence not fit for consumption from entering into the normal supply channels. Condemnation of unfit subsistence at this point will also result in an economy of transport means available for port clearance. In those situations where a headquarters transportation terminal command is operating one or more subsidiary installations handling subsistence, or the inspection requirements of the terminal command exceed the capability of the inspection section, it is necessary to augment this section by the attachment of veterinary service detachments. Normally, the TALOG surgeon authorizes the staff veterinarian to exercise operational control over veterinary detachments not further assigned or attached to subordinate units. When the number of veterinary service detachments present exceeds the span of control, then operational control is exercised through a headquarters veterinary service team. The number of veterinary service detachments required to accomplish the TALOG food inspection mission can be calculated by determining the average daily tonnage of Class I supply cleared from ports of entry and shipped to Class I supply depots. Normally the large veterinary service detachment or multiples of this detachment, augmented as required by smaller detachments to bring inspection capability into agreement with inspection requirements, are used to provide food inspection service in the COMMZ.

(b) Veterinary animal service. Veterinary service for TALOG units, whose animal strength justifies such service, is provided by the attachment of veterinary personnel trained in animal care. Veterinary small hospital detachment teams are provided for the care and treatment of animals evacuated from the combat zone or disabled in the COMMZ.

APPENDIX II TO ANNEX B

PROPOSED MEDICAL SERVICE ORGANIZATION AND OPERATIONS OF THE TASCOM

1. Purpose. The purpose of this appendix is to present and discuss the proposed medical service system in the Theater Army Support Command (TASCOM) to include organizations, operational concepts, and other data to illustrate how medical support will be provided to the theater of operations under the TASTA-70 concept.

2. General.

a. The TASTA-70 concept has required no major changes in doctrine and only minor changes in organization for medical service support in a theater of operations. Medical depots remain assigned to the Medical Command under the TASTA-70 concept. Some concepts of operations and operating procedures have been changed to foster compatibility with the TASTA-70 concept. The basic change affecting the COMMZ medical service support structure is in the organizational framework within which the medical organization lies and the subsequent overall medical organization structure.

b. Under the TASTA-70 concept the area occupied by the COMMZ is essentially a time and distance void between the combat force and its sources of manpower and materiel replenishment. Support activities are dispersed laterally and in depth for passive defense and to take advantage of terrain and existing transportation nets; but their fundamental orientation is always perpendicular to the combat zone. TASTA-70 provides a simplified, flexible, and responsive service support system with increased emphasis on the utilization of automatic data processing equipment.

c. The Theater Army is organized into a TASCOM and one or more field armies. The TASCOM and the field army are on the same level and both commands are assigned all of the combat service support capabilities needed to perform their missions.

d. The TASCOM is organized into six separate commands. Five of these, the personnel, supply and maintenance, engineer, transportation, and medical command are the "mission" commands which directly support combat operations. To perform their missions, these commands echelon or align themselves along a perpendicular axis joining the theater base and the combat zone. The sixth command, the area support command, is established for the control of subordinate units which furnish direct support to the TASCOM. These units primarily support the "mission" commands and are organized and oriented to conform to their needs.

3. The Medical Command, TASCOM. (See Figure B-II-1.)

a. The TASTA-70 concept centralizes command and control of all medical functions in a medical command with decentralized operations of the Army-wide and integrated medical service system of the COMMZ. The medical command, as one of the major commands of the TASCOM, will consist

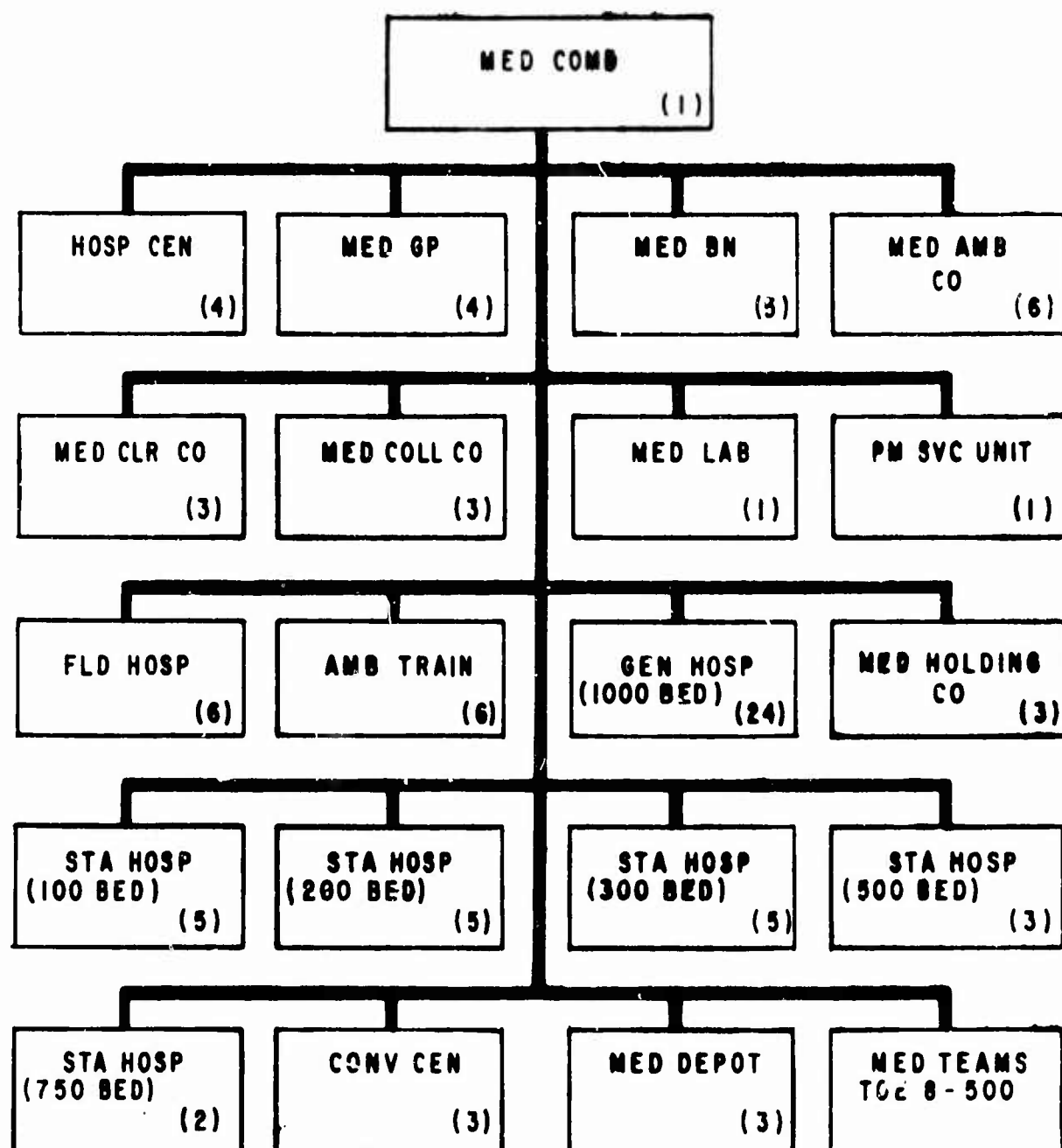


FIGURE B-II-1 MEDICAL COMMAND

of hospital centers and medical groups. Components of the hospital center normally include general hospitals and convalescent centers. All other medical units will normally operate under medical group control.

b. Command and staff relationships.

(1) Command relationships. The medical command commander reports directly to the TASCOM commander. The coordination of medical command and staff matters with theater army and its staff is normally through the TASCOM commander. Coordination of medical command matters with commands parallel and subordinate to TASCOM will also be through command channels.

(2) Staff relationships. In addition to the Medical Command there is a Medical Branch organic to the ACS/Personnel, TASCOM.

(a) There is no TASCOM surgeon. The TASCOM commander may, at his discretion, designate either the medical command commander or the medical staff officer assigned to the Medical Branch, ACS/Personnel to act in this capacity. When one of the above is designated the TASCOM Surgeon, he will assume the functions, responsibilities and duties of a surgeon.

(b) The Medical Branch, ACS/Personnel, consists of a medical staff officer, medical plans officer, medical administrative assistant and enlisted assistants. The medical staff officer is authorized direct access to the commander on medical matters of command interest.

(c) The functions of the medical staff officer are to:

1. Advise the commander and staff on professional technical medical matters.

2. Develop, prepare, and coordinate with the Medical Command, the medical portions of TASCOM plans and policies.

3. Make plans and recommendations for the procurement and assignment of medical units to the Medical Command.

4. Exercise technical supervision over medical training throughout the command including sanitation, first aid, and hygiene for all troops.

5. Evaluate and disseminate medical intelligence in coordination with ACS/Security, Plans and Operations.

6. Advise and assist ACS/Civil Affairs in planning and coordinating civil public health operations.

7. Plan and coordinate the medical aspects of rear area security and damage control within the TASCOM.

c. Scope of medical service support to TASCOC. The development of a medical service support organization and system for the TASCOC requires consideration of the following medical functions and procedures:

- (1) Command and control.
- (2) Hospitalization.
- (3) Evacuation.
- (4) Area medical service.
- (5) Medical supply and maintenance.
- (6) Preventive medicine.
- (7) Medical laboratory.
- (8) Dental service
- (9) Veterinary service
- (10) Medical regulating.
- (11) Patient accounting and reporting.

d. Mission. The mission of the medical command is to provide medical service support to the combat zone and to Army units and units of other services located in the communications zone.

e. Concept of operations.

- (1) Command and control.

(a) Medical command. The medical command headquarters provides for the command, planning, and continuous operation of the medical service of the TASCOC. The medical command is assisted in this function by hospital centers and medical groups.

(b) Hospital center. The hospital center commands and controls two or more general hospitals, a convalescent center and, when required, other medical service units. The hospital center headquarters correlates and coordinates the activities of the attached hospitals and by grouping professional skills, the center can provide specialized treatment facilities.

(c) Medical groups. Medical groups are assigned to the medical command to effect command, control, staff planning, and supervision of operations, training, and administration of attached medical service units. The nature of COMMZ medical service requires that medical groups be employed to perform dual mission responsibilities consisting of medical support to forces in the combat zone and medical support to COMMZ troops.

Support to the combat zone consists of relieving the combat zone of its patients and reinforcing combat zone medical service. Generally, the medical groups located in proximity to the combat zone will be charged with this responsibility and will furnish area medical support to COMMZ troops within their zone of operations. Medical groups located well within the COMMZ will generally provide medical support exclusively within the COMMZ and will normally consist of units furnishing station type hospitalization, short haul patient evacuation, patient holding, and other services. Medical groups may also contain such medical attachments as medical laboratories, preventive medicine units, dental units, veterinary units, medical intelligence units and dispensaries. Units are readily reallocated between groups by action of the medical command to accomplish shifts in workload.

(d) Medical battalion. Medical battalions are assigned to the medical command and attached to medical groups as required to perform the mission of evacuation and treatment. They provide command, control, planning, supply, and vehicle maintenance services for attached units.

(2) Hospitalization. Hospitalization and treatment facilities provide patients with the therapy necessary to return them to duty or to prepare them for evacuation to the CONUS. Hospitalization is provided for patients from medical treatment facilities located both in the combat zone and the COMMZ.

(a) The general hospital, 1000-bed, is a fixed installation designed to provide hospitalization to include medical treatment of a definitive and specialized nature, observation, and studies of patients with serious and/or complicated illnesses, diseases, injuries, or combat incurred wounds. This hospital is a part of the normal evacuation system. In addition to receiving patients from the combat zone, general hospitals also provide treatment for patients transferred from station hospitals, field hospitals, and dispensaries as well as for personnel admitted directly from units located within the COMMZ. This hospital is assigned to the medical command to satisfy theater fixed-bed requirements.

(b) Station hospitals are fixed hospitals which normally serve a limited assigned area within the COMMZ. They do not routinely receive patients from the combat zone. These hospitals are organized and classified according to their patient capacity (100-200-300-500-750) and are established at locations in the COMMZ where there is a sufficient concentration of military personnel to require local hospitalization.

(c) The field hospital is organized and designed to provide hospitalization to troops in the COMMZ when temporary hospital facilities are required. When completely established in one location, this unit can provide hospitalization for 400 patients. However, it may be divided into three 100-bed hospitalization units, each of which is capable of independent operation for a limited period of time. It is not in the normal evacuation system and is normally allocated on the basis of four per COMMZ in support of a field army. When required, this unit is used to provide a hospital facility for prisoners of war.

(d) Convalescent centers are designed to recondition and prepare for return to full duty, those patients who no longer require hospitalization. Convalescent center beds are not charged against theater fixed bed requirements.

(3) Evacuation. Medical evacuation is intimately related to patient treatment and assures en route patient care between points where more definitive treatment is provided.

(a) Evacuation from the combat zone.

1. The evacuation of patients from the combat zone to the communications zone requires detailed planning and coordination between the medical brigade in the field army and the medical command in the COMMZ. The medical command also coordinates evacuation requirements with the agencies controlling air and rail transportation assets.

a. Evacuation by the Air Force. The medical command commander furnishes the Air Force information on the number of patients to be evacuated, their location in the combat zone, and their destination in the COMMZ. The Air Force furnishes the medical command commander an air evacuation schedule which may or may not provide sufficient transport for all patients awaiting evacuation. The medical command commander furnishes evacuation instructions to the COMMZ medical facilities concerned and to the medical brigade. Patients are transported by Army ambulance units to Air Force casualty staging facilities or Army medical holding units established at airfields in the combat zone, where they are enplaned in accordance with the air evacuation schedule. At the destination airfields in the COMMZ, Air Force casualty staging facilities or Army medical holding units receive and hold the patients until they are transported by Army ambulance units to receiving hospitals.

b. Evacuation by Army medical ambulance units. Necessary planning and coordination is accomplished between the medical brigade and the medical command. Evacuation missions are accomplished by ambulance companies of COMMZ medical groups supporting the combat zone. Ground ambulances utilized for this function are a supplement to normal air and rail transportation when these means are not available or sufficient for this mission, and when the distances involved are not too great.

c. Evacuation by rail ambulance trains. Planning and coordination is accomplished between the medical brigade and the medical command regarding the numbers and locations of patients to be evacuated from the combat zone. The medical command requests rail engines for the ambulance trains from the TASCOM movement control center. The movement control center furnishes the medical command with a train schedule regarding pick up and destination stations. The medical command commander issues implementing instructions to the COMMZ medical facilities concerned and to the medical brigade. The medical brigade and the medical command are responsible for the transportation of patients to and from railheads and for establishing holding facilities at these locations, when required.

2. The concepts of patient evacuation from the combat zone have been over-simplified for the sake of clarity and ready understanding of the employment of various evacuation means. The actual accomplishment of this function is complex and requires detailed consideration and coordination of all factors involved. The operating procedure facilitating patient evacuation is medical regulating which will be discussed later in detail.

(b) Evacuation within the COMMZ.

1. Medical evacuation units are placed throughout the COMMZ based on population concentrations for the purpose of evacuating sick or injured to an initial treatment facility and, when required, to a subsequent treatment facility for more definitive treatment. Arrangements for this service are made between the treatment facilities concerned and the medical unit responsible for furnishing evacuation support.

2. For patient evacuation to general hospitals from any other COMMZ medical treatment facility, coordination must be effected through the medical command. The planning, coordination, and execution of patient evacuation within the COMMZ will be accomplished in much the same manner as described above for the evacuation of patients from the combat zone.

(c) Types of evacuation means available to the medical command.

1. Ambulance companies and detachments. Ambulance companies and detachments are attached to medical battalions for control purposes and are utilized for evacuation and reinforcement of the combat zone and for area support of the COMMZ. These units are equipped with 3/4 ton ambulances or ambulances buses, as appropriate.

2. Helicopter ambulance detachments. Helicopter ambulance detachments are attached to medical groups, as required, for the purpose of furnishing emergency air evacuation of patients to an initial treatment facility and for the subsequent movement of critical patients between treatment facilities.

3. Rail ambulance trains. Ambulance trains normally evacuate the bulk of those patients evacuated from the combat zone by surface means. Ambulance train units, less rail engines and crews, are assigned to the medical command.

4. Air Force evacuation means. The Air Force has the primary responsibility for air evacuation of patients from the combat zone to the COMMZ. The Army has no control over the type aircraft utilized by the Air Force and can only recommend the scheduling of the evacuation operation. In any event, the accomplishment of the air evacuation mission will be in accordance with the flight schedule published by the Air Force.

(d) Holding facilities. Holding facilities, either Army or Air Force are intimately related to the evacuation process, yet they are also closely associated with the care and stabilization of a patient's condition as opposed to the definitive treatment provided in hospitals. Nevertheless, holding facilities are discussed in this study in connection with evacuation and treatment because it is the evacuation of patients which necessitates the existence of holding facilities. It is a general principle that holding installations are established and operated in the vicinity of railheads and airfields utilized for evacuation purposes.

(4) Area medical service.

(a) The area support command has no medical units assigned or attached and must receive medical support from medical facilities of the medical command on an area basis. This concept of medical service involves the delineation of support responsibility by geographical area. Medical support for COMMZ personnel can be provided most economically and efficiently on an area basis by extension of dispensary services from hospital facilities. Medical units required for this service are allotted based upon troop strength.

(b) To insure adequate medical support to area support groups, coordination between the area support command and the medical command is necessary. An exchange of information through effective liaison will provide the medical command commander with the extent and location of troop concentrations to be supported, and will provide the area support command commander with the type and amount of service to be furnished. The senior medical commander located within the geographical boundaries of an area support group will normally provide medical staff advice for the area support group commander. Standing operating procedures will be developed by the medical command and the area support command governing the relationship between each area support group commander and the senior medical commander in his area.

(c) Rear area security and area damage control. The senior medical commanders located within the boundaries of area support groups will normally be responsible for the development of medical plans in support of the area support group commander's RAS/ADC plan. Once developed, these plans will be coordinated with the medical command to insure availability of adequate medical service to accomplish all assigned missions.

(5) Medical supply and maintenance. Management of medical supplies will be accomplished by medical commodity managers located with the Medical Command, TASCOT and Medical Brigade, FASCOM. Receipt, storage, and issue of medical supplies is performed by the Army Medical Depot (FASCOM) and Medical Depot (TASCOT) which are linked by a digital communications system to the FASCOM and TASCOT Medical ICP.

(a) Segregation of medical supplies from mixed shipments will take place at points of discharge (beaches, ports, or air terminals) or at a transportation terminal established at a designated inland location.

(b) Throughput of medical supplies designated for the field army will be accomplished by the transportation movement control center in coordination with the medical command ICP.

(c) Medical supplies designated for COMMZ medical depots will generally be moved from points of discharge by appropriate movement elements of the transportation command. Medical supplies for COMMZ medical depots which are not segregated and shipped from discharge points, will be shipped to medical depots from the inland transportation terminals having a segregation mission.

(d) COMMZ medical depots provide both general and direct medical supply and medical equipment maintenance support. Additional direct support medical supply points may be established, when required, with cellular supply detachments of TOE 8-500.

(e) COMMZ medical units normally obtain needed medical supplies and equipment on a supply point distribution basis although maximum use is made of back haul medical evacuation means in the distribution of medical supplies to using units where possible. When required, movement elements of the transportation command will be utilized for unit distribution. Movement of medical supplies into the field army is normally accomplished by the transportation command.

(f) COMMZ medical units submit their medical supply requirements to designated medical depots. Unsatisfied and replenishment direct support requirements are reported to the Medical Command ICP by the servicing medical depot.

(g) Automatic data processing equipment will be utilized to facilitate medical supply operations in the COMMZ. Inventory control of TASCAM medical supply assets is centralized at Medical Command ICP. All medical supply support to the combat zone will be as directed by the Medical Command ICP. (See Annex F, ADP Implementation.)

(6) Preventive medicine. A preventive medicine field service unit provides comprehensive preventive medicine support to the COMMZ.

(7) Medical laboratory. The medical laboratory provides complete facilities to support all medical units of the communications zone to include: comprehensive laboratory facilities; assistance in the identification of nuclear, biological, and chemical agents; medical research; technical inspection; manufacture of diagnostic agents; support of epidemiological studies; and the establishment of a histopathology center.

(8) Dental service. Dental service in the communications zone is furnished through hospital and area dental facilities. All hospitals, as well as convalescent centers, have organic dental services for the support of personnel admitted to these facilities. Dental

personnel of medical dispensaries and dental service units provide area dental service throughout the COMMZ based on troop concentrations.

(9) Veterinary service. The veterinary service supports the COMMZ by providing treatment and hospitalization for military animals as well as by inspecting and supervising pertinent matters relating to food products destined for consumption by COMMZ troops.

(10) Medical regulating. (See Figure B-II-2.)

(a) Medical regulating is the operating procedure that coordinates and facilitates patient treatment and evacuation. It cannot be divorced from other medical activities as it is an inseparable part of the entire medical service support system.

(b) Purpose. The main purpose of medical regulating in the theater is to control the movement of patients from the combat zone, and from station and field hospitals into general hospitals in the COMMZ. The formal system starts in the hospitals of the field army, and in the station and field hospitals of the COMMZ.

(c) Medical regulating of patients from the combat zone.

1. On a daily basis hospital physicians report to the registrar the patients requiring evacuation the following day. The registrar performs the medical regulating function within each hospital. He assembles all pertinent information and transmits a report to the controlling medical group headquarters. This report, in essence, is a request for transportation for patients as well as a notification of the numbers requiring evacuation. The report also includes numbers of patients by diagnostic categories. The categories to be reported are a matter of policy and standing operating procedures within the theater, and will usually include, as a minimum, surgical, medical, and neuro-psychiatric patient categories. These three categories must be included since they have a definite and predictable impact on both transportation and hospital bed requirements. The registrar's report also categorizes patients as to their transportability; whether they are litter or ambulatory cases. This factor has a definite bearing on transportation requirements. Patients may also be categorized as to official status, such as US military personnel, US civilians, and prisoners of war. The medical regulating officer (MRO) at each medical group headquarters consolidates the information received from hospitals of the group, and submits the compiled data to the FASCOM MRO. The FASCOM MRO consolidates the reports for the field army and transmits the data to the TASCOR MRO.

2. The TASCOR MRO must know the location and the availability of vacant general hospital beds in which patients can be placed. This information is obtained by the TASCOR MRO on a daily basis from reports submitted by the general hospitals. The report contains the status of beds available at the time of submission plus a forecast of dispositions during the following 24 hours. On the basis of this information and known requirements, the TASCOR MRO determines the distribution of the incoming patients to the general hospitals.

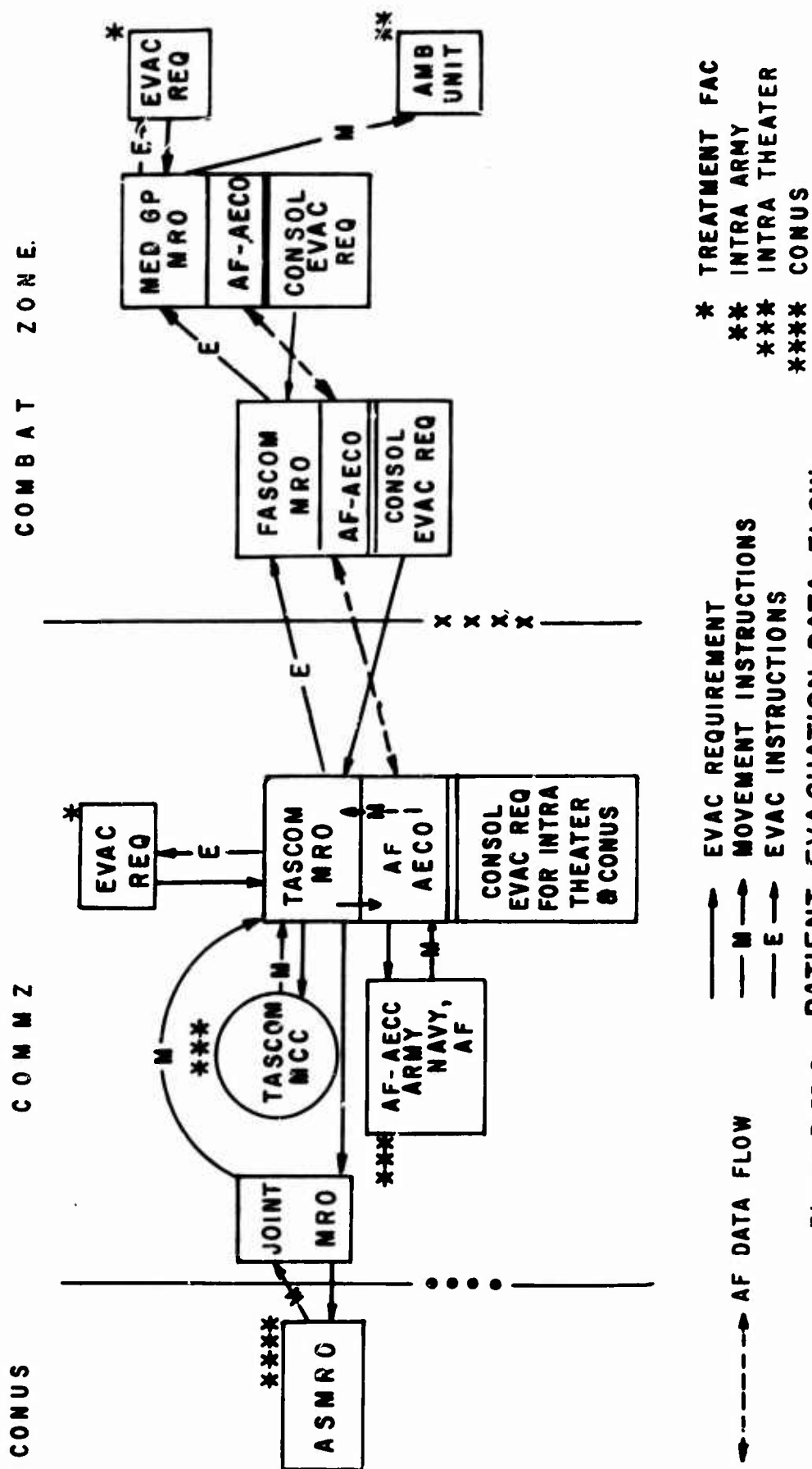


Figure B-II-2. PATIENT EVACUATION DATA FLOW

3. To assist the TASCOT MRO in developing an evacuation plan, all accumulated information is processed through the TASCOT PAC computer. Printout data facilitates the preparation and implementation of the evacuation plan.

4. At this point in the procedure one additional factor is considered. The TASCOT medical command does not possess the type transportation needed to move large numbers of patients from the combat zone to the general hospitals located in the COMZ. The TASCOT MRO accordingly submits his evacuation requirements to the army movement control center (MCC) and/or to the Air Force aeromedical evacuation control officer (AECO). The MCC processes this request through its computer and issues transportation instructions to the TASCOT MRO. The AECO at TASCOT headquarters is an Air Force officer assigned to an Air Force aeromedical evacuation squadron. The mission of the squadron is to control the movement of and provide in-transit medical care to patients while under control of the Air Force. An AECO is also located at the TASCOT, Medical Command, the FASCOM, Medical Brigade, and at each of the brigade's medical group headquarters. At each headquarters, the AECO works closely with the MRO and provides detailed flight schedules, technical information on aircraft, and patient preparation requirements for air movement.

5. The Air Force provides casualty staging facilities at each airfield where patients are enplaned or deplaned. Responsibilities for patients are exchanged at these sites between the Air Force and Army. FASCOM medical brigade evacuation units transport patients to the CSF's. The CSF's assume control of the patients, care for them, load them into aircraft at on-load airfields and off-load them at destination airfields.

6. The TASCOT AECO forwards the evacuation requirements received from the TASCOT MRO to a Theater Air Force agency, the Aeromedical evacuation control Center (AECC). This agency coordinates with other members of the Air Force, Army transportation representatives, and Navy agencies with respect to forward movement of cargo and personnel aboard the Air Force aircraft. Certain of these aircraft are then designated to evacuate patients on a back haul basis. Air Force aircraft seldom go forward solely for the purpose of returning patients. When the AECC secures a firm allocation of aircraft, a detailed flight schedule is returned to the TASCOT AECO. The TASCOT AECO disseminates this flight evacuation schedule to the TASCOT MRO and to subordinate AECO's.

7. The TASCOT MRO then issues evacuation instructions to subordinate MRO's and other medical units concerned. The hospital centers must prepare to receive the patients at the destination airfields and arrange for their movement to designated general hospitals. Field army medical group MRO's notify attached hospitals and direct ambulance units to move the patients to the on-load airfield in accordance with flight schedules.

(d) Medical regulating of patients within the COMMZ. The same procedures are followed by the station and field hospitals of the COMMZ with regard to notifying the TASCOR MRO the locations, numbers, and types of patients for movement to general hospitals.

(11) Patient accounting and reporting. The medical command commander is responsible for the consolidation of medical statistics derived from patient accounting and reporting procedures for all theater army forces. Included in the internal organization of the medical command are two sections that are responsible for the processing of reports related to patient accounting and reporting procedures.

(a) The medical records and statistics section collects, processes, and analyzes statistical data concerning the sick and injured. This section is charged with the compilation of medical reports for all theater army forces.

(b) The historical section maintains liaison with the historical sections of other appropriate agencies; collects and analyzes source material for medical histories; collects and prepares illustrative material; prepares preliminary historical accounts with complete documentation; and recommends policies for the collection and compilation of historical records.

f. ADPS.

(1) The role of ADPS for field army and COMMZ medical service is to provide for rapid transmittal of data, instantaneous retrieval of data, automated preparation of reports, and automation of many other techniques and procedures previously accomplished by manual means. Initially, this role will be applied to functions pertaining to:

(a) Patient accounting and reporting. The process which provides for the collection, recording, summarizing, and reporting of data regarding patients hospitalized, and/or evacuated in the army in the field.

(b) Medical supply and maintenance. The administrative procedures concerned with the procurement, storage, distribution, and maintenance of items of medical supply.

(c) Medical regulating. The aspect of medical operations which coordinates and controls the movement of patients to the medical facilities which are best able to provide care at a given time.

(d) Medical intelligence. The area of medical service concerned with the collection, evaluation, analysis, and interpretation of all available information which is immediately or potentially significant to military planning and which concerns factors that affect the health and welfare of man and animals in actual or potential areas of operations.

(2) The medical service does not, at this time, anticipate that the workload to be automated will be substantial enough to warrant a sole-user computer system. It is anticipated that other computer facilities in the field army and COMMZ will provide the medical service with necessary computer support. It is visualized that a type ADPE will be required by the medical service to operate and manage the medical supply and maintenance function. The equipment envisioned should have the capability of processing a large volume of data. However, equipment have a capability somewhat less than that of a computer would be adequate. Input/output devices will provide the means for entry and exit from the automated system. On-line input/output devices will be required at medical command and control headquarters, medical depots, and hospitals.

(3) Since computer to computer transmission will be available and input/output devices will be directly connected to a computer facility located in the echelons of command where the medical headquarters or unit is operating, medical data will be able to flow linearly through the successive headquarters and agencies concerned with medical service.

(4) ADP implementation (See Annex F).

4. See FM 8-17 (Test) Medical Service, Communications Zone for description of Army Medical Service Units, TASCOR.

ANNEX C

PRINCIPLES OF FIELD MEDICAL SERVICE

1. Purpose. The purpose of this annex is to present the principles of the field medical service as they form the basis for all medical service doctrine. It is important that these principles be clearly understood by planners and decision makers for military medical situations.

2. Six Principles of Field Medical Service.

a. Continuity. Medical service must be continuous. Interruption in continuity of treatment will cause an increase in morbidity and mortality. Once begun, treatment does not terminate until the patient has been returned to duty or discharged from the service. Medical support for combat forces is organized into levels--unit, division, field army, communications zone, and zone of interior. Procedures should be standardized to assure accomplishment of all required treatment and other medical functions appropriate at all levels.

(1) In combat, the necessity for providing medical service arises the minute contact with the enemy is made, since casualties begin to accumulate as soon as troops come under fire. The operation of essential medical installations will not be terminated until their functions have been assumed by another agency. A reasonable length of time must elapse between the opening of a new installation and the closing of the old one. Patients already enroute to the old installation may be received during this period. Evacuation is a continuing function which cannot be suspended while adjustments are made.

(2) The hospitalization/evacuation system is based on the doctrine that subordinate elements are provided their logistical support by the next higher echelon; i.e., supporting levels provide evacuation, in accordance with the established evacuation policy. This doctrine extends from the responsibility of the zone of interior to evacuate and to hospitalize all long-term patients from a theater of operations to the responsibility of the battalion medical platoon to evacuate patients from the rifle companies of the battalion. No level of medical service is normally given a responsibility for evacuation that extends farther than its rearmost medical installation.

(3) No patient is evacuated farther to the rear than his physical condition warrants or the military situation requires. Every case evacuated without sufficient reason imposes an unnecessary burden on three agencies the man's organization, which must go shorthanded until he is returned or replaced; the replacement system which must procure, equip, train, and transport a man to take his place; and the medical service, which must provide evacuation means, hospital facilities, and trained medical personnel to care for him. The sorting (classifying) of patients to determine which can be treated and returned to duty and which must be evacuated for further treatment is, therefore, a most important function of every medical installation in the hospitalization/evacuation

system. In order to plan and operate the medical service efficiently, it is necessary to know to what extent patients will be retained at any given level of medical service. The evacuation policy of the command designates the maximum period during which patients may be retained for treatment at the medical facilities within that command. Patients who, in the opinion of responsible medical officers, cannot be returned to duty within the prescribed time are evacuated by the first available and suitable transportation, providing such travel will not aggravate their disabilities.

(4) The employment of medical means must be simple in nature, particularly in the combat area. In forward areas, the patient load is apt to be too great for the means if treatment must be complete for all who need it. Stations must not be immobilized by instituting long and complicated procedures. Each level of medical service employs the simplest standard treatment procedure that will provide the desired benefits to the patient. Definitive treatment refers to generally accepted procedures necessary to produce the ultimate recovery of the patient. Except for minor injuries and sicknesses which can be treated with minor surgery or available medicines, treatment in forward areas is usually limited to those emergency measures which will preserve life and limb and prepare the patient for movement to a place where the time and facilities are available for curative treatment. Since many measures applied as medical aid are the first steps to more detailed treatment, it is impossible to fix the specific point at which emergency medical treatment ends and definitive treatment begins. Somewhat arbitrarily, the term "hospitalization" is used to indicate the relatively complete medical care and treatment provided for serious cases of those needing care for a long time, as contrasted with the emergency treatment rendered at forward aid stations and clearing stations or the outpatient treatment provided at a hospital.

b. Control. Control of medical resources must rest with the medical commander or medical staff officer having responsibility within the command for providing medical service. Medical organization must parallel the tactical organization. Medical service must be planned and operated in conformity with specific strategic and tactical plans and general command policies. The surgeon must keep informed of all plans and intentions of the command supported. Medical service must be unobtrusive so as not to interfere with tactical operations.

(1) If the medical service is to respond to the commander's plans in a timely manner, the surgeon who is responsible for its direction must be able to influence the operations of the medical units which carry out the medical mission. Basically, the mission of medical units is to conserve fighting strength by serving the commands with which they are associated. There are several ways in which the medical means available to a command may be employed to provide this service: assignment, attachment, direct support, and general support.

(2) Since the objective of military medicine is to conserve trained manpower, medical means must be disposed and employed to do the

most good for the greatest number. Maximum medical support must be given to the combat elements that have the most important mission. When a wide disparity exists between the requirements for medical service and the means available to provide such service, it may be necessary to favor those patients who can be returned to immediate duty, rather than the more seriously injured, in assigning treatment and evacuation priorities.

(3) The treatment to be performed at each level of medical service must be commensurate with the means which can be made available at that level. Medical means are not unlimited; therefore, it is essential that control be retained at the highest medical level consistent with the tactical situation. For this reason, medical units are usually not attached if their mission can be accomplished either by direct support or general support.

c. Proximity. The medical means must be as close to the casualty as the time/distance factor and the tactical situation permit. Early collection, sorting, and evaluation of the patient must be accomplished to assure that no patient is evacuated farther to the rear than his physical condition requires nor the military situation demands.

(1) The speed with which medical treatment can be instituted is of extreme importance in reducing morbidity and mortality. As soon as the medical service receives a patient, it is confronted with two alternatives. It must either move the patient to a medical treatment facility, or it must move the medical treatment facility to the patient. Two factors will govern the choice: the military situation and the condition of the patient. The medical installation must not be located so far forward as to interfere with combat operations or to subject it to enemy interference which will hinder its operation; yet it must not be located so far to the rear that the patient's chances for survival will be jeopardized unnecessarily because of the time required to reach it. Thus, a location which provides close medical support in a situation where helicopters are available for evacuation is quite different from that required for close support when evacuation is provided by litter bearers operating over difficult terrain.

(2) Usually, the best solution will be a combination of the two alternatives. In forward areas, close medical support provided by locating medical treatment facilities as far forward as possible, moving them when necessary to maintain contact with supported units, and by rapid evacuation of patients to these facilities. When the tactical situation precludes the movement of the medical treatment facility far forward, then emphasis must be placed on evacuation; and when evacuation time exceeds that period which is considered necessary to hold morbidity and mortality to a minimum, then the medical treatment facility must be moved closer to the patient, or faster and more efficient evacuation means must be provided. In either case, the patient and the treatment facility must be brought together as promptly as possible so that proper care can be instituted.

d. Flexibility. Medical service must be flexible. Unexpected change is the rule on the battlefield. A change in tactical plans or operations may require redistribution of the medical means. The medical commander and the medical staff planner must be in a position to shift their medical support to meet the changing circumstances of the supported units. Alternate plans and plans for reserve are essential.

(1) The allotment of medical means is based on the military situation and the tactical plan in being at the time. It should always be remembered, however, that any tactical operation may, without much advance warning, depart from the initial plan, either because of enemy counteraction or as a result of the decision of the commander to exploit newly discovered weaknesses or errors on the part of the enemy. As a consequence, the medical service must be prepared to respond to sudden changes in the tactical situation.

(2) As in the case of combat units, maintaining an adequate reserve contributes to the flexibility which the medical service must possess. No more troops should be committed and no more installations should be established than are required for the task at hand or for the obvious needs of the immediate future. Once committed, a limitation is imposed on the availability of a medical unit for other employment. The establishment of a station immobilizes the unit for a period, the length of which will depend upon the elaborateness of the installation and the number and type of patients in it. When his medical reserve has been exhausted, or depleted to the point of inadequacy, the first concern of the surgeon is to reconstitute a reserve from units already committed. If this is impossible, he must seek reinforcements.

e. Mobility. A prime requirement of medical support is the maintenance of contact with supported troops. Medical troops must have the same mobility, physically and psychologically, as the units they support. Mobility may be retained by the timely and rapid evacuation of patients, thus preventing loss of mobility by an overload of facilities.

(1) The mobility of a unit is measured by the extent to which it can move its organic personnel and equipment with its organic transportation. A fully mobile unit can complete such movement in one trip; a semimobile unit can complete it only by shuttling. A fixed unit is one which has only a minimum of administration vehicles and can move only by the use of additional transportation from some other source. With regard to medical units, mobility has an additional connotation inasmuch as a medical treatment facility must be patient-free before it can be moved.

(2) Medical treatment units should retain mobility as long as possible by only partially establishing their stations until the demands of the situation require commitment of their total means. Once entirely committed, the only way the mobility of a medical unit can be regained is by the prompt evacuation of its patients. An immobilized medical treatment unit can continue its support only in a "stabilized" situation. In the advance, it must be kept mobile or replaced by another unit. In a retrograde movement, it may necessarily have to be abandoned. When

the mobility of a medical unit is jeopardized by the accumulation of patients who are not adequately prepared for further evacuation, it may be necessary to leave a small holding detachment with such patients when the main part of the unit is moved closer to the troops served.

(3) Casualties are rarely distributed evenly over a battlefield. They tend rather to be concentrated in "areas of casualty density." Since the irregular distribution of casualties may place an insurmountable burden on certain medical agencies at a time when others are relatively unoccupied, preference in the allotment of medical means should be given to those areas where the greatest casualty density can be expected. The probable location of areas of casualty density can be deduced from an analysis of the tactical plans in connection with a study of the terrain. They will be found where the heaviest concentration of fire can be brought to bear upon the densest population of troops. This situation ordinarily prevails in those areas of major tactical importance for here the commander concentrates his combat power, and here the enemy must oppose to the limit of his strength. It is essential that the surgeon obtain adequate information of the enemy situation and the plan for the employment of the troops to be supported so that he can properly allocate the medical service to provide continuous preferential support to troops in the areas of highest probable casualty density. This information must be available to the surgeon in time to permit medical units to be moved to the battle positions before the action begins.

f. Conformity. Conformity with the tactical plan is one of the most fundamental elements in the provision of field medical support. It is only by analysis of the commander's plan of operation that we determine the size and composition of the medical troop list, the degree of "Mobility" required, maintain "Proximity," and insure "Continuity" of medical service. Medical service must be ever present in the right places, at the right time, and in the right amounts.

ANNEX D

STATUS OF EQUIPMENT FOR ARMY MEDICAL SERVICE

1. Purpose. The purpose of this annex is to present a list of items anticipated for type classification and introduction into field medical units by 1970 and to estimate the numbers and types of ADPE required for the Army Medical Service under the TASTA-70 concept.

2. Medical Items Anticipated for the Army Medical Service. The items have been listed under new and product improvement headings. Where appropriate, each of these lists are further broken down by QMDO, QMR, and SDR.

a. New items:

QMR

Medical Unit, Self-Contained, Transportable (MUST). Action Control Number: 6531. The purpose of this requirement is to provide a mission-oriented medical treatment system which is designed and equipped to facilitate rapid establishment and disestablishment, and to provide a clean, contamination-free, controlled environment in which to treat patients. It is anticipated that the MUST will be in the army in the field prior to 1970.

SDR

(1) X-ray Apparatus, Lightweight, Field. Action Control Number: 0034. The purpose of this requirement is to provide a lightweight man-portable X-ray unit which can be used without attachment to an outside power source. It will be capable of using either conventional or Polaroid film for the purpose of producing roentgenographs for the purpose of determining the presence of foreign matter or fractures.

(2) Field Dental X-ray Processing Unit, Self-Contained. Action Control Number: 0039. The purpose of this requirement is to provide a lightweight, portable, high speed, automatic means for processing periapical type dental film. The device is capable of operating without a darkroom.

(3) Litter Inflatable. Action Control Number: 0040. The purpose of this requirement is to provide a reliable lightweight inflatable litter for use in combat areas. The litter will be significantly improved over the current standard litter because of reduced weight, reduced cube when not in use, and improved transportability. It will be particularly suitable for airborne, mountain, arctic, and jungle operations, since it will afford the capability of floating patients over water, or dragging over snow or ice.

(4) Oxygen Extractor. Action Control Number: 7486. The purpose of this device will be to extract 99.9 percent pure oxygen from the atmosphere for resuscitation and/or treatment of patients in the

field. This device will greatly reduce or entirely eliminate the requirement to provide medical oxygen in heavy, refillable cylinders, as is currently the practice.

(5) X-ray Processing Unit, Field, Medical X-ray Film. Action Control Number: 0034. The purpose of this requirement is to provide a small lightweight portable medical X-ray film developer to serve as a companion item for the lightweight X-ray unit.

(6) Bed Folding, Hospital, Field. Action Control Number: 0030. The purpose of this objective is to provide a lightweight, compact, and readily transportable bed to replace the beds in current use. Those in current use weigh approximately 79 pounds and the developmental item will weigh less than 40 pounds. Also, the developmental bed will be capable of being raised at both the head and foot sections without disturbing the feet of the bed which will rest on the floor surface at all times.

(7) Sterilizer, Pressure, Fuel Heated, Lightweight, Field. Action Control Number: 0035. The purpose of this requirement is to provide a sterilizer with a weight of approximately 120 pounds to replace that currently in use which weighs approximately 475 pounds. The developmental item will be capable of being heated by an inclosed gasoline heater, by electricity or steamline.

(8) Dental Treatment Set, Field, Hand Carried, Forward Areas. Action Control Number: 0037. The purpose of this set is to provide a compact, lightweight, easily transported case which contains the instruments and materials necessary to perform emergency and interim dental procedures on patients remote from dental treatment facilities. The set will provide capabilities which are far beyond those of the current available treatment set.

(9) Handpiece, Dental, with Self-Contained Power Units. Action Control Number: 0038. The purpose of this device is to provide a lightweight, high speed-low torque, low speed-high torque, dental handpiece with a self-contained power unit for use in conjunction with the dental treatment set.

b. Product improvement items:

QMDO

None.

QMR

None.

SDR

None

3. Automatic Data Processing Equipment Anticipated for Army Medical Service.

a. Requirements for:

- (1) Patient accounting and reporting.
- (2) Medical supply and maintenance.
- (3) Medical regulating.
- (4) Medical intelligence.

b. Machine time: Amount of machine time cannot be determined at this time.

c. Priority: A priority cannot be determined at this time. However, a general statement can be made that input, computer utilization, and printout delays, which would exceed the time required for manual operations, cannot be tolerated without a corresponding deterioration in the medical service furnished the theater of operations.

d. Identification of equipment required: The medical service concept visualized the utilization of a series of input/output devices on a sole-user basis as the means of entry and exit from the supporting computer facility. The automated workload at this time is not substantial enough to warrant a sole-user computer system; however, other computers will be used on a shared basis.

e. Quantities and assignment of ADPE to medical units, FASCOM.

(1) Evacuation hospitals. A means of communication which transmits information to its command headquarters in the same language/format required for entry into the ADP system by an on-line input/output device. This will require approximately 24 input/output devices.

(2) Medical groups. One input/output device will be utilized by each medical group in the FASCOM. This will require 6 input/output devices.

(3) Medical brigade. One input/output device will be utilized by the medical brigade. This will require one input/output device.

(4) Army medical depot. One input/output development will be utilized by each platoon. This will require four input/output devices.

f. Quantities and assignment of ADPE to medical units, TASCOT.

(1) Medical groups. One input/output device will be utilized by each medical group in the TASCOT. This will require approximately three input/output devices.

(2) General hospitals. A means of communication which transmits information to its command headquarters in the same language/format required for entry into the ADP system by an on-line input/output device. This will require approximately 24 input/output devices.

(3) Hospital centers. One input/output device will be utilized by each hospital center. This will require approximately three input/output devices.

(4) Medical command. One input/output device will be utilized by the medical command. This will require one input/output device.

(5) Medical depot. One input/output device will be utilized by each depot. This will require approximately three input/output devices.

ANNEX E

TROOP LISTS

1. Purpose.

a. The purpose of this annex is to develop the medical troop lists for the field army and the communications zone in a theater of operations under the TASTA-70 concept for:

- (1) Twelve division force.
- (2) Eight division force.

b. This annex will also develop the medical troop lists for a theater of operations consisting of:

- (1) A three division independent corps force.
- (2) An independent mechanized division force.

2. Methodology.

a. In the field army, medical units were allocated generally on the number of divisions or units to be supported.

b. The COMMZ medical requirements were computed based on the units to be supported and by the number of fixed beds required which are functions of admission rates, accumulation factors, evacuation policy, dispersion allowance, and total troop strength. For the purpose of this study, casualty rates, dispersion allowances, and accumulation factors from FM 101-10 and from the statistical division of the OTSG were utilized.

c. Rates, factors, and other data utilized to develop the COMMZ medical command troop list:

- (1) Theater evacuation policy: 60 days.
- (2) Strengths for each force model:
 - (a) Twelve division force:
 1. Combat zone: 430,000.

2. COMMZ: 210,000.

3. Theater strength: 640,000.

(b) Eight division force:

1. Combat zone: 287,000.

2. COMMZ: 140,000.

3. Theater strength: 427,000.

(c) Three division force:

1. Combat force: 93,500.

2. COSCOM: 46,500.

3. Theater strength: 140,000.

(d) One division force: 39,000.

(3) Formula for computing fixed beds: Fixed beds =
admission rate X troop strength X accumulation X dispersion
(thousands) factor factor

(4) Formula for 12 and 8 division forces:

D&NBI	1.62	model force strength	14.67	1.25
BC	.55	model force strength	25.57	1.25

(5) Formula for 3 and 1 division forces:

D&NBI	2.07	model force strength	14.67	1.25
BC	.37	model force strength	25.57	1.25

(6) Distribution of fixed beds:

(a) Eighty percent: general hospitals.

(c) percent: station hospitals.

d. Command and control medical units were determined based on span of control requirements and the distances involved.

3. Troop List for Twelve Division Force. See Appendix I to Annex E.
4. Troop List for Eight Division Force. See Appendix II to Annex E.
5. Troop List for Three Division Force. See Appendix III to Annex E.
6. Troop List for One Division Force. See Appendix IV to Annex E.

TWELVE DIVISION FORCE THEATER ARMY TROOP LIST													
MTEL/TOE NR.	COMBAT SVC SUP UNIT	UNIT TITLE	UNIT STR	CORPS FORCE		FIELD ARMY		THEATER ARMY		TASCOM		TOTAL	
				NR	STR	NR	STR	NR	STR	NR	STR	NR	STR
8-57E	MED SVC	Medical Holding Co	90			3	270			3	270	6	540
8-111(P)		HHD Medical Command	191							1	192	1	192
8-112E		HHD Medical Bde	67			1	67					1	67
8-122E		HHD Medical Gp	34			6	204			4	136	10	340
8-126E		HHD Medical Bn	34			9	306			5	170	14	476
8-127E		Med Amb Co	97			15	1455			6	582	21	2037
8-128E		Med Clearing Co	127			15	1905			3	381	18	2286
8-129E		Med Collecting Co	190			3	570			3	570	6	1140
8-137E		Med Air Amb Co	159			3	477					3	477
8-187D		Medical Depot	107							3	321	3	321
8-204E		Prev Med Svc Unit	114			1	114			1	114	2	228
8-500D		Medical Svc Org					2695				2660		5355
8-510D		Field Hospital	213							6*	1278	6	1278
8-520E		Amb Train, Rail	42							6	252	6	252
8-551D		Gen Hosp 1000 Bed	586							24	14064	24	14064
8-563E		Sta Hosp 100 Bed	78							5	390	5	390
8-564D		Sta Hosp 200 Bed	127							5	635	5	635
8-565E	Sta Hosp 300 Bed	216							5	1080	5	1080	
8-566E	Sta Hosp 500 Bed	333							3	999	3	999	
8-567D	Sta Hosp 750 Bed	442							2	884	2	884	
8-571E	Mobile Army Surg H	118			12	1416					12	1416	
8-581E	Evac Hosp	309			24	7416					24	7416	
8-590E	Convalescent Ctr	242			1	242			3	726	4	968	
8-650E	Medical Lab	111			1	111			1	111	2	222	
8-667E	Army Med Depot	198			1	198					1	198	
					TOTAL		17446			25815		43261	

(See Attached Sheet)

*Two field hospitals for PW's

APPENDIX I

TWELVE DIVISION FORCE THEATER ARMY TROOP LIST

MTEL/TOE NR	COMBAT SVC SUP UNIT	UNIT TITLE	UNIT STR		CORPS FORCE		FIELD ARMY		THEATER ARMY		TASCOM		TOTAL	
			NR	STR	NR	STR	NR	STR	NR	STR	NR	STR	NR	STR
8-500D	MED SVC	Medical Svc Org												
Team AC		Company Headquarters	8				4	32					4	32
Team AE		HQ Unit Receiving Cen	13										1	13
Team AF		HQ Vet Prof Svc	4				1	4					1	4
Team AG		HQ Med Prof Svc	15				3	45					1	15
Team AH		HQ Hospital Center	37										4	60
Team AI		HQ Dental Prof Svc	4				5	20					4	148
Team AJ		Blood Bank Svc Hq	8										3	32
Team FB		Medical Supply Det	18										1	8
Team FC		Medical Supply Det	33											
Team GA		Optical Detachment	7											
Team GB		Optical Det Augmen	2											
Team GC		Med Equip Maint Det	5											
Team GD		Med Equip Maint Det	9											
Team IA		Vet Lg Animal Hosp Det	17											
Team IB		Vet Lg Animal Disp Det	5											
Team ID		Vet Sml Animal Hosp D	14				1	14					1	28
Team IE		Vet Sml Animal Disp D	7				6	42					4	70
Team JA		Vet Svc Det, Small	6				3	18					3	18
Team JB		Vet Svc Det, Large	54				1	54					4	216
Team KA		Surgical Det	7				6	42					12	84
Team KB		Orthopedic Det	7				6	42					9	63
Team KC		Shock Det	4				3	12					6	24
Team KD		Maxillofacial Det	7				3	21					5	35
Team KE		Neurosurgical Det	7				6	42					9	63
Team KF		Thoracic Det	7				3	21					5	35

TWELVE DIVISION FORCE THEATER ARMY TROOP LIST

MTL/TOE NR	COMBAT SVC SUP UNIT	UNIT TITLE	UNIT STR		CORPS FORCE		FIELD ARMY		THEATER ARMY		TASCOM		TOTAL	
			NR	STR	NR	STR	NR	STR	NR	STR	NR	STR	NR	STR
Team KG	MED SVC	Med Trtmt Det (Chem Agents)	14				3	42			2	28	5	70
Team KH		X-ray Detachment	3				1	3			1	3	2	6
Team KI		Dental Operating Det	2				10	20			3	6	13	26
Team KJ		Dental Svc Det	36				28	1008			14	504	42	1512
Team KK		Den Prosth Det Mobile	4				14	56			7	28	21	84
Team KL		Den Prosth Det Fixed	7								4	28	4	28
Team KN		Central Den Lab	28								1	28	1	28
Team KO		Psychiatric Det	19								1	19	4	76
Team KP		Renal and Elec Metab	35				3	57			4	140	4	140
Team LA		Prev Med Con Det	11											
Team LB		Prev Med Survey Det	11											
Team MA		Dispensary	17											
Team MB		General Dispensary	21								9	153	9	153
Team MC		General Dispensary	39								2	42	2	42
Team NA		Blood Processing Det	16								9	351	9	351
Team NB		Blood Collecting Det	10								1	16	1	16
Team NC		Blood Distribution D	8								6	60	6	60
Team OA		Medical Det	9				1	8			1	8	2	16
Team PA		Med Illustration Det	6				30	270			30	270	60	540
Team QA		Med Intell Det	12								1	6	1	6
Team RA		Helicopter Amb Det	36				3	36			2	24	5	60
Team RB		Ambulance Det	14				12	432			6	216	18	648
Team RC (T)		Air Crash Rescue	15				18	270			6	84	6	84
Team RD (T)		Air Crash Rescue	7				12	84			6	90	24	360
Team SA		Medical Control	1								4	28	16	112
Team SB		Medical Support	3											

EIGHT DIVISION FORCE THEATER ARMY TROOP LIST															
MTEL/TOE NR	COMBAT SVC SUP UNIT	UNIT TITLE	UNIT		CORPS FORCE		FIELD ARMY		THEATER ARMY		TASCOM		TOTAL		
			STR		NR	STR	NR	STR	NR	STR	NR	STR	NR	STR	NR
8-57E	MED SVC	Med Holding Co	90				2	180				2	180	4	360
8-111(P)		HHD Medical Command	192									1	192	1	192
8-112E		HHD Medical Bde	67				1	67						1	67
8-122E		HHD Medical Gp	34				4	136				3	102	7	238
8-126E		HHD Medical Bn	34				6	204				3	102	9	306
8-127E		Med Amb Co	97				10	970				4	388	14	1358
8-128E		Med Clearing Co	127				10	1270				2	254	12	1524
8-129E		Med Collecting Co	190				2	380				2	380	4	760
8-137E		Med Air Amb Co	159				2	318						2	318
8-187D		Medical Depot	107									2	214	2	214
8-204E		Prev Med Svc Unit	114				1	114				1	114	2	228
8-500D		Medical Svc Org	(See attached sheet)					1828					1843	2	3671
8-510D		Field Hospital	213									4*	852	4	852
8-520E		Ambulance Train, Rail)	42									4	168	4	168
8-551D		Gen Hosp 1000 Bed	586									16	9376	16	9376
8-563E		Sta Hosp 100 Bed	78									3	234	3	234
8-564D	Sta Hosp 200 Bed	127									3	381	3	381	
8-565E	Sta Hosp 300 Bed	216									3	648	3	648	
8-566E	Sta Hosp 500 Bed	333									3	999	3	999	
8-567D	Sta Hosp 750 Bed	442									1	442	1	442	
8-571E	Mobile Army Surg H	118				8	944						8	944	
8-581E	Evacuation Hosp	309				16	4944						16	4944	
8-590E	Convalescent Center	242				1(-)	194				2	484	3(-)	678	
8-650E	Medical Lab	111				1(-)	86				1(-)	86	2(-)	172	
8-667E	Army Med Depot	198				1(-)	168						1(-)	168	
							TOTAL	11803				17439		29242	

*One field hospital for PW's

APPENDIX II

EIGHT DIVISION FORCE THEATER ARMY TROOP LIST

MTEL/TOE NR.	COMBAT SVC SUP UNIT	UNIT TITLE	UNIT STR		CORPS FORCE NR STR		FIELD ARMY NR STR		THEATER ARMY NR STR		TASCOM NR STR		TOTAL NR STR	
8-500D	MED SVC	Med Svc Org					3	24					3	24
Team AC		Company Hqs	8										1	13
Team AE		HQ Unit Receiving C	13										1	13
Team AF		HQ Vet Prof Svc	4				1	4					2	8
Team AG		Hq Med Prof Svc	15				2	30					3	45
Team AH		Hq Hospital Center	37										3	111
Team AI		Hq Dental Prof Svc	4										3	111
Team AJ		Blood Bank Svc Hq	8				3	12					5	20
Team FB		Medical Sup Det	18										1	8
Team FC		Medical Supply Det	33											
Team GA		Optical Det	7											
Team GB		Optical Det Augmen	2											
Team GC		Med Equip Maint Det	5											
Team GD		Med Equip Maint Det	9											
Team IA		Vet Lg Animal Hosp D	17											
Team IB		Vet Lg Animal Disp D	5											
Team ID		Vet Sm Animal Hosp D	14				1	14					2	28
Team IE		Vet Sm Animal Disp D	7				4	28					7	49
Team JA		Vet Svc Det, Small	6				2	12					2	12
Team JB		Vet Svc Det, Large	54				1	54					3	162
Team KA		Surgical Det	7				4	28					8	56
Team KB		Orthopedic Det	7				4	28					6	42
Team KC		Shock Det	4				2	8					4	16
Team KD		Maxillofacial Det	7				2	14					3	21
Team KE		Neurosurgical Det	7				4	28					6	42
Team KF		Thoracic Det	7				2	14					3	21

EIGHT DIVISION FORCE THEATER ARMY TROOP LIST

MTEL/TOE NR	COMBAT SVC SUP UNIT	UNIT TITLE	UNIT		CORPS FORCE		FIELD ARMY		THEATER ARMY		TASCOM		TOTAL	
			STR	NR	NR	STR	NR	STR	NR	STR	NR	STR	NR	STR
Team KG	MED SVC	Med Trtmt Det (Chem Agents)	14	2		28					1	14	3	42
Team KH		X-ray Detachment	3								1	3	1	3
Team KI		Dental Oper Det	2	2		4					5	10	7	14
Team KJ		Dental Svc Det	36	19		684					9	324	28	1008
Team KK		Den Prosth Det Mobile	4	15		40					5	20	15	60
Team KL		Den Prosth Det Fixed	7								2	14	2	14
Team KN		Central Den Lab	28								1	28	1	28
Team KO		Psychiatric Det	19	2		32					1	19	3	57
Team KP		Renal and Elec Metab	35								3	105	3	105
Team LA		Prev Med Con Det	11											
Team LB		Prev Med Survey Det	11											
Team MA		Dispensary	17											
Team MB		General Dispensary	21								6	102	6	102
Team MC		General Dispensary	39								2	42	2	42
Team NA		Blood Processing Det	16								6	234	6	234
Team NB		Blood Collecting Det	10								1	16	1	16
Team NC		Blood Distribution D	8	1		8					4	40	4	40
Team OA		Medical Detachment	9	20		180					1	180	2	16
Team PA		Med Illus Det	6								20	360	40	360
Team QA		Med Intell Det	12	2		24					1	6	1	6
Team RA		Helicopter Det	36	8		288					2	24	4	48
Team RB		Ambulance Det	14								4	144	12	432
Team RC(T)		Air Crash Rescue	15	12		180					4	56	4	56
Team RD(T)		Air Crash Rescue	7	8		56					4	60	16	240
Team SA		Medical Control	1								4	14	10	70
Team SB		Medical Support	3								2			

THREE DIVISION FORCE INDEPENDENT CORPS TROOP LIST													
MTEL/TOE NR.	COMBAT SVC SUP UNIT	UNIT TITLE	UNIT STR	CORPS FORCE		FIELD ARMY COSCOM		THEATER ARMY		TASCOM		TOTAL	
				NR	STR	NR	STR	NR	STR	NR	STR	NR	STR
8-57E	MED SVC	Med Holding Co	90			1	90			1	90	2	180
8-111(P)		HHD Medical Command	191										
8-112E		HHD Medical Bde	67							1(-)	54	1(-)	54
8-122E		HHD Medical Group	34			2(+)	68			2	68	4	136
8-126E		HHD Medical Bn	34			3	102			1	34	4	136
8-127E		Med Amb Co	97			4	388			2	194	6	582
8-128E		Med Clearing Co	127			5	635			1	127	6	762
8-129E		Med Collecting Co	190			1	190			1	190	2	380
8-137E		Med Air Amb Co	159			1	159					1	159
8-187D		Medical Depot	107							1(-)	93	1(-)	93
8-204E		Prev Med Svc Unit	114							1(-)	84	1(-)	84
8-500D		Medical Svc Org	(See attached sheet)										
8-510D		Field Hosp	213				745			1	213	1	213
8-520E		Amb Train, Rail	42										
8-551D		Gen Hosp 1000 Bed	586							5	2930	5	2930
8-563E		Sta Hosp 100 Bed	78							2	156	2	156
8-564D		Sta Hosp 200 Bed	127							2	254	2	254
8-565E		Sta Hosp 300 Bed	216							3	648	3	648
8-566E		Sta Hosp 500 Bed	333							1	333	1	333
8-567D		Sta Hosp 750 Bed	442										
8-571E		Mobile Army Surg H	118			3	354					3	354
8-581E		Evac Hosp	309			6	1854					6	1854
8-590E		Convalescent Ctr	242							1	242	1	242
8-650E		Medical Lab	111			1(-)	86			1(-)	86	2(-)	172
8-667E		Army Med Depot	198			1(-)	114					1(-)	114
					TOTAL		4785				6492		11277

R-III-1

APPENDIX III
(+)One Medical Group Increased by Part B, TOE 8-122.

THREE DIVISION FORCE INDEPENDENT CORPS TROOP LIST											
MTPL/TOE NR.	COMBAT SERVICE UNIT	UNIT TITLE	UNIT STR	CORPS FORCE		FIELD ARMY COSCOM		THEATER ARMY		TASCOM	TOTAL
				NR	STR	NR	STR	NR	STR	NR	STR
8-500D	MED SVC	Medical Service Org	8								
Team AC		Company Headquarters	13								
Team AE		Hq Unit Receiving Cen	4								
Team AF		Hq Vet Prof Service	15								
Team AG		Hq Med Prof Service	37								
Team AH		Hq Hospital Center	4								
Team AI		Hq Dental Prof Svc	8								
Team AJ		Blood Bank Svc Hq	18								
Team FB		Medical Supply Det	33								
Team FC		Medical Supply Det	7								
Team GA		Optical Detachment	2								
Team GB		Optical Det Aug	5								
Team GC		Med Equip Maint Det	9								
Team GD		Med Equip Maint Det	17								
Team IA		Vet Lg Animal Hosp Det	5								
Team IB		Vet Lg Animal Disp Det	14								
Team ID		Vet Sml Animal Hosp Det	7								
Team IE		Vet Sml Animal Disp Det	6								
Team JA		Vet Svc Det, Small	54								
Team JB		Vet Svc Det, Large	7								
Team KA		Surgical Detachment	7								
Team KB		Orthopedic Detachment	4								
Team KC		Shock Detachment	7								
Team KD		Maxillofacial Det	7								
Team KE		Neurosurgical Det	7								
Team KF		Thoracic Detachment	7								

THREE DIVISION FORCE INDEPENDENT CORPS TROOP LIST												
MTEL/TOE NR.	COMBAT SVC SPT UNIT	UNIT TITLE	UNIT STR	CORPS FORCE		FIELD ARMY COSCOM		THEATER ARMY		THEATER BASE		TOTAL
				NR	STR	NR	STR	NR	STR	NR	STR	NR STR
Team KG	MED SVC	Med Trmt Det (Chem Agt)	14			1	14					1 14
Team KH		X-ray Detachment	3									
Team KI		Dental Operating Det	2			4	8			2	4	6 12
Team KJ		Dental Svc Det	36			6	216			3	108	9 324
Team KK		Den Pros Det Mobile	4			3	12			2	8	5 20
Team KL		Den Pros Det Fixed	7							1	7	1 7
Team KN		Central Den Lab	28									
Team KO		Psychiatric Det	19			1	19					1 19
Team KP		Renal and Elec Metab	35							1	35	1 35
Team LA		Pvnt Med Cont Det	11			1	11					1 11
Team LB		Pvnt Med Survey Det	11			1	11					1 11
Team MA		Dispensary	17							3	51	3 51
Team MB		General Dispensary	21							1	21	1 21
Team MC		General Dispensary	39							1	39	1 39
Team NA		Blood Processing Det	16									
Team NB		Blood Collecting Det	10							2	20	2 20
Team NC		Blood Distribution Det	8							1	8	1 8
Team OA		Medical Detachment	9			10	90			10	90	20 180
Team PA		Med Illus Detachment	6									
Team QA		Med Intel Detachment	12			1	12			1	12	2 24
Team RA		Hel Ambulance Det	36			6	216			2	72	8 288
Team RB		Ambulance Detachment	14							2	28	2 28
Team RC (T)		Air Crash Rescue	15			3	45			2	30	5 75
Team RD (T)		Air Crash Rescue	7			2	14			1	7	3 21
Team SA		Medical Control	1									
Team SB		Medical Support	3									

INDEPENDENT (MECHANIZED) DIVISION FORCE TROOP LIST															
MTEL/TOE NR	COMBAT SVC SUP UNIT	UNIT TITLE	UNIT		CORPS FORCE		FIELD ARMY SUPCOM		THEATER ARMY		TASCOM		TOTAL		
			STR	NR	NR	STR	NR	STR	NR	STR	NR	NR	STR		
8-57E	MED SVC	Med Holding Company	90												
8-111(P)		HHD Medical Command	191												
8-112E		HHD Medical Bde	67												
8-122E		HHD Medical Gp	34					34				1+	34	2	68
8-126E		HHD Medical Bn	34					0				1	34	1	34
8-127E		Med Amb Co	97					1				1	97	2	194
8-128E		Med Clearing Co	127					2				1	127	3	381
8-129E		Med Collecting Co	190									1(-)	74	1(-)	74
8-137E		Med Air Amb Co	159											1	159
8-187D		Medical Depot	107					1							
8-204E		Prev Med Svc Unit	114												
8-500D		Medical Svc Org	(See attached sheet												
8-510D		Field Hospital	213						177			1	262	1	439
8-520E		Amb Train, Rail	42										213		213
8-551D		Gen Hosp 1000 Bed	586												
8-563E		Sta Hosp 100 Bed	78										156	2	156
8-564D		Sta Hosp 200 Bed	128										254	2	254
8-565E	Sta Hosp 300 Bed	216													
8-566E	Sta Hosp 500 Bed	333									1	333	1	333	
8-567D	Sta Hosp 750 Bed	442									1	442	1	442	
8-571E	Mobile Army Surg H	118					1								
8-581E	Evacuation Hosp	309					2								
8-590E	Convalescent Ctr	242						118							
8-650E	Medical Lab	111						618							
8-667E	Army Med Depot	198													

APPENDIX IV

INDEPENDENT (MECHANIZED) DIVISION FORCE TROOP LIST														
MTEL/TOE NR	COMBAT SVC SUP UNIT	UNIT TITLE	UNIT		CORPS FORCE		FIELD ARMY SUPCOM		THEATER ARMY		TASCOM		TOTAL	
			STR	NR	NR	STR	NR	STR	NR	STR	NR	NR	STR	
8-500D	MED SVC	Medical Svc Org	8				1	8			1	8	2	16
Team AC		Company Headquarters	13											
Team AE		Hq Unit Receiving Cen	4											
Team AF		Hq Vet Prof Svc	15											
Team AG		Hq Med Prof Svc	37											
Team AH		Hq Hosp Ctr	4											
Team AI		Hq Den Prof Svc	8				1	4					1	4
Team AJ		Blood Bank Svc Hq	18				0	0						
Team FB		Medical Sup Det	33				1	18			1	18	2	36
Team FC		Medical Sup Det	7											
Team GA		Optical Det	2				1	2			1	2	2	4
Team GB		Optical Det Aug	5				1	5			1	5	2	10
Team GC		Med Equip Maint Det	9											
Team GD		Med Equip Maint Det	17											
Team IA		Vet Lg Anim Hosp Det	5											
Team IB		Vet Lg Anim Disp Det	14											
Team ID		Vet Sml Anim Hosp D	7											
Team IE		Vet Sml Anim Disp D	6											
Team JA		Vet Svc Det, Small	54				2	12			1	7	1	7
Team JB		Vet Svc Det, Large	7										2	12
Team KA		Surgical Detachment	7											
Team KB		Orthopedic Det	4											
Team KC		Shock Detachment	7											
Team KD		Maxillofacial Det	7											
Team KE		Neurosurgical Det	7				1	7					1	7
Team KF		Thoracic Det	7											

INDEPENDENT (MECHANIZED) DIVISION FORCE TROOP LIST														
MTEL/TOE NR.	COMBAT SVC SUP UNIT	UNIT TITLE	UNIT		CORPS FORCE		FIELD ARMY SUPCOM		THEATER ARMY		TASCOM		TOTAL	
			STR	NR	NR	STR	NR	STR	NR	STR	NR	NR	STR	
Team KG	MED SVC	Med Trtmt Det (Chem Agents)	14											
Team KH		X-ray Detachment	3											
Team KI		Den Operating Det	2											
Team KJ		Den Svc Det	36								1	36	5	10
Team KK		Den Prosth Det Mobile	4								1	4	2	72
Team KL		Den Prosth Det Fixed	7											8
Team KN		Central Den Lab	28											
Team KO		Psychiatric Det	19											
Team KP		Renal and Elec Metab	35											
Team LA		Prev Med Con Det	11				1	11			1	11	2	22
Team LB		Prev Med Survey Det	11				1	11			1	11	2	22
Team MA		Dispensary	17											
Team MB		General Dispensary	21										1	21
Team MC		General Dispensary	39											
Team NA		Blood Processing Det	16											
Team NB		Blood Collecting Det	10											
Team NC		Blood Distribution Det	8											
Team OA		Medical Detachment	9				3	27			5	45	8	72
Team PA		Med Illus Det	6											
Team QA		Med Intell Det	12											
Team RA		Hel Amb Det	36								2	72	2	72
Team RB		Ambulance Det	14											
Team RC(T)		Air Crash Rescue	15				1	15			1	15	2	30
Team RD(T)		Air Crash Rescue	7				1	7			1	7	2	14
Team SA		Medical Control	1											
Team SB		Medical Support	3											

ANNEX F

ADP IMPLEMENTATION

1. Purpose.

a. To describe the TASTA-70 medical service use of ADPE to include the phased evolutionary approach to currently available methods, the improved methods planned for installation by the end of CY 1968 and the ultimate introduction of the Combat Service Support System (CS₃).

b. To describe an alternate means of processing data to insure continuity of operations in the event of temporary or total disruption of automated data processing means.

c. To describe the approach, both manual and automated, contemplated for performance of the medical service functions shown below. (The medical intelligence function has been excluded since it is not a candidate for inclusion into the CS₃ portion of the Automatic Data Systems Within the Army in the Field program (ADSAF). This function has been considered for inclusion within the Tactical Operations System (TOS).

(1) Patient accounting/reporting.

(2) Medical regulating.

(3) Medical supply.

2. Basis for ADP Requirements.

a. Planning for the medical care of wounded personnel in modern warfare requires factual information, much of it statistical in nature. Experience indicates a requirement exists to develop improved methods of collecting medical data for use in forecasting the present and future needs of the medical service.

b. The following requirements for ADP support of medical service functions in a theater of operations were identified in the TASTA-70 concept:

(1) To record, transmit, process, and summarize data in support of patient accounting, medical regulating, medical supply, medical intelligence, and medical reporting.

(2) To provide the timely acquisition, processing, and reporting of medical data.

(3) To provide timely information that will help reduce the time lag in the treatment and movement of patients.

c. The general objectives of the automation of selected medical service functions are to:

- (1) Improve effectiveness.
- (2) Reduce the response time for retrieving critical information.
- (3) Reduce the administrative workload.

3. Discussion.

a. General. With the introduction of CS3 and the TASTA-70 concept which envisions computers at each major echelon of support, it is anticipated that medical service information will flow as illustrated on Figure F-1 and will be processed as depicted on Figure F-2. The system will include the items of equipment presently specified for CS3 and additional items necessary to support medical service functions. Input/output (I/O) devices will be required to provide the means for entry into and exit from the automated system. In addition, each major medical treatment facility will require a means of communication which transmits information to its command headquarters in the same language/format required for entry into the ADP system by on-line I/O devices. As a minimum, the medical service will require some type of on-line I/O device at command and control headquarters, medical depots, and hospitals. Additionally, some type of ADP will be required to support the operation and management of the medical supply and maintenance function. The equipment needed for this function should be capable of processing a large volume of data.

b. Patient accounting and reporting.

(1) Introduction. Patient accounting begins at the time patients are located by medical service personnel and are brought to, or enter, a treatment facility where the facts of admission, diagnosis, and/or disposition are recorded. This recording procedure is repeated each time a patient is subsequently received by another treatment facility. As patient information is collected, it is consolidated, summarized, disseminated locally, and forwarded to the next higher echelon. The PAC computer at TASCAM maintains a master medical records file containing information received from all the medical treatment facilities in the theater of operations. The master file provides information for statistical reports required by the Office of The Surgeon General, statistical information, and a basis for reconstructing facility files at lower echelons. The patient accounting/reporting function includes the following:

- (a) The collection and organization of patient and facility information.
- (b) Consolidation and summarization of information.
- (c) Preparation and dissemination of reports.

(2) Current methods used to process and transmit information. As this function applies to medical units of the army in the field, the collection, organization, consolidation, and summarization of patient data

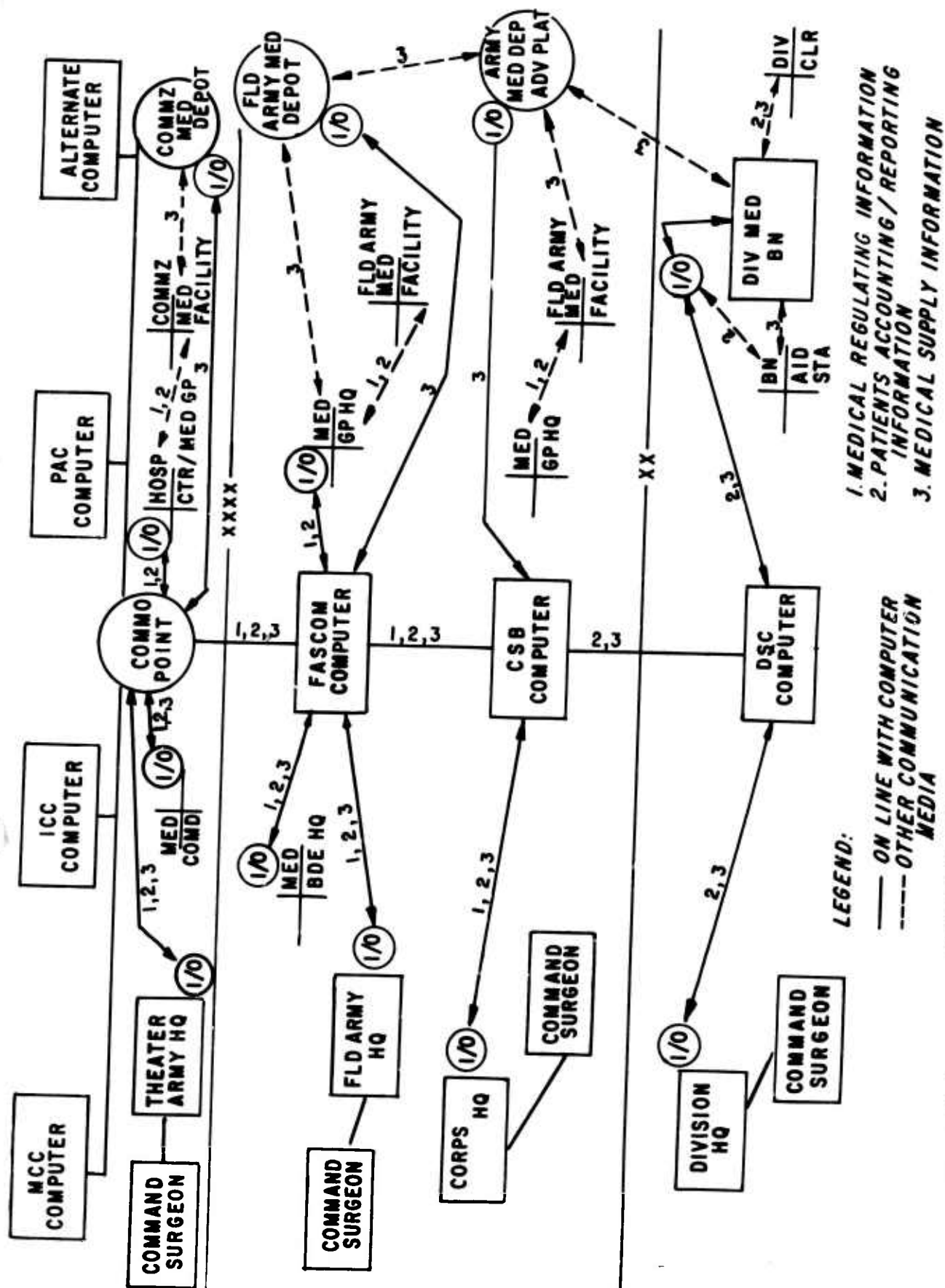


FIGURE F-1

MEDICAL SERVICE INFORMATION FLOW

ADSAP SYSTEM

METHODS OF PROCESSING AND COMMUNICATIONS

FIGURE F-2

1. <u>MEDICAL REGULATING</u>	2. <u>PATIENTS ACCOUNTING/REPORTING</u>	3. <u>MEDICAL SUPPLY</u>
FOR COMZ		
a. PAC Computer	a. PAC Computer	a. ADP/ICP ADP/ICP
b. I/O's Located:	b. I/O's	b. I/O's
(1) Hospital Centers	(1) Share those indicated for Medical Regulating	(1) Medical Depots
(2) Medical Command Headquarters		(2) Share those indicated for Medical Regulating
(3) Medical Group Headquarters		
c. Responsive communications to subordinate units		

F-4

FOR A FIELD ARMY		
a. FASCOM Computer	a. FASCOM Computer	a. CS3 Computer System for Switching Information to Army Medical Depot (Medical ICP)
	b. I/O's shared with those indicated for Medical Regulating	b. I/O Located:
		(1) Medical Depot: Base Platoon
		(2) Share those indicated for Medical Regulating

ADSAF SYSTEM

METHODS OF PROCESSING AND COMMUNICATIONS (CONTINUED)

<u>1. MEDICAL REGULATING</u>	<u>2. PATIENTS ACCOUNTING/ REPORTING</u>	<u>3. MEDICAL SUPPLY</u>
FOR A CORPS		
a. CSB Computer for Switching only	a. CSB Computer for Switching Information forwarded to Theater and for Processing Patients	a. *Primarily Performed Manually with Necessary ADP Support Performed under Control of Medical Depot
b. I/O's Located: Medical Group Headquarters	b. I/O's Shared with Medical Regulating	b. I/O: (1) Advanced Medical Platoon (2) Other available means
c. Responsive communications to subordinate units		
FOR A DIVISION		
No Formal Regulating-Patient Flow Information Processed Manually	a. DSC Computer b. I/O Located: DSC Remote Device	a. Performed Manually b. Communications-- (1) Primarily by Messenger and/or Ambulance (2) DSC Remote Device

*Wartime Organization--In peacetime, the advanced supply platoon is located with the base platoon at the Field Army Medical Depot.

are presently performed using manual methods and procedures. Dissemination and distribution are accomplished by messenger, electrical transmission, and other available communication means. (See Figure F-3.)

(3) Interim techniques planned for installation by the end of CY 68. It is not contemplated that this function will be incorporated into any of the interim systems being designed or tested; and until the ultimate introduction of CS₃, only improvements in the current manual methods and procedures are foreseen.

(4) Introduction of CS₃.

(a) Automation. With the introduction of CS₃, the patient accounting/reporting function will use automated methods. A standard format will be utilized by all reporting elements to record and report accounting data.

1. Source information required. The following type of information is collected by recording the important facts at the time of occurrence.

a. Unit data - (Unit identification, bed capacity, bed status, report period.)

b. Patient data - (Admission, diagnosis, disposition, name, organization.)

c. Special data - (Special selected information which is collected and reported as it occurs.)

2. Transmission.

a. Transmission of patient information to the computer center will be on a daily basis; however, situations will occur where it may become necessary to forward the information more frequently. Medical reporting elements will transmit patient information to the medical command and control headquarters via a means of communication which transmits information in the same language/format required for entry into the ADP system by on-line I/O devices who in turn will transmit patient accounting information to the computer center via an on-line I/O device.

b. From the FASCOM medical group, information will enter the system through the appropriate Corps Support Brigade (CSB) computer where it will be automatically switched to the Field Army Support Command (FASCOM) computer. At this point, the source input information is entered into the computer for processing. In TASCUM the medical group/hospital center transmits information directly into the PAC computer where it will be processed. The PAC computer provides the processing support for two distinct purposes. It processes theater army medical information in the support of intertheater medical service operations and provides a master medical records file for the patient accounting and reporting function.

EXISTING SYSTEM

METHODS OF PROCESSING AND COMMUNICATIONS

1. MEDICAL REGULATING
2. PATIENTS ACCOUNTING/REPORTING
3. MEDICAL SUPPLY

FOR COMZ

- a. Performed Manually
 - b. Communications--by available means
- a. Performed Manually
 - b. Communications--by available means
- a. Normally performed on Punch Card Machine or computer; time shared with other supply classifications
 - b. Communications--
 - (1) Messenger/Medical Vehicles
 - (2) Army Logistics Net
 - (3) Transceivers
 - (4) Teletype
 - (5) Radio
 - (6) Telephone

FIGURE F-3

EXISTING SYSTEM

METHODS OF PROCESSING AND COMMUNICATIONS (CONTINUED)

- | | | |
|------------------------------|--|--------------------------|
| 1. <u>MEDICAL REGULATING</u> | 2. <u>PATIENTS ACCOUNTING/</u>
<u>REPORTING</u> | 3. <u>MEDICAL SUPPLY</u> |
|------------------------------|--|--------------------------|

FOR A FIELD ARMY

- | | | |
|-----------------------|-----------------------|--------------------------|
| a. Performed Manually | a. Performed Manually | a. Normally performed on |
| b. Communications--by | b. Communications--by | Punch Card Machine or |
| available means | available means | computer; time shared |
| | | with other supply |
| | | classifications or |
| | | Punch Card Machine |
| | | Communications-- |
| | | (1) Messenger/Medical |
| | | Vehicles |
| | | (2) Army Logistics Net |
| | | (3) Transcaivers |
| | | (4) Teletype |
| | | (5) Radio |
| | | (6) Telephone |

EXISTING SYSTEM

METHODS OF PROCESSING AND COMMUNICATIONS (CONTINUED)

1. <u>MEDICAL REGULATING</u>	2. <u>PATIENTS ACCOUNTING/ REPORTING</u>	3. <u>MEDICAL SUPPLY</u>
------------------------------	--	--------------------------

FOR A CORPS

- | | | |
|---|---|--|
| <p>a. Performed Manually</p> <p>b. Communications--by available means</p> | <p>a. Performed Manually</p> <p>b. Communications--by available means</p> | <p>a. Performed Manually*</p> <p>b. Communications--</p> <p>(1) Messenger and/or Ambulance</p> <p>(2) Army Logistics Net</p> <p>(3) Transceivers</p> <p>(4) Teletype</p> <p>(5) Radio</p> <p>(6) Telephone</p> |
|---|---|--|

FOR A DIVISION

- | | | |
|---|---|---|
| <p>No Formal Regulating-Patient Flow Information Processed Manually</p> | <p>a. Performed Manually</p> <p>b. Communications--by available means</p> | <p>a. Performed Manually</p> <p>b. Communications--</p> <p>(1) Messenger and/or Ambulance</p> <p>(2) Army Logistics Net</p> <p>(3) Transceivers</p> <p>(4) Teletype</p> <p>(5) Radio</p> <p>(6) Telephone</p> |
|---|---|---|

*Wartime Organization--In peacetime, the advanced supply platoon is located with the base platoon at the Field Army Medical Depot.

(b) Output.

1. From the FASCOM computer, the output of the patient accounting/reporting function may be divided into three categories:

a. Reports prepared for the command surgeons and major medical commanders.

b. Summary information to be transmitted to the Personnel Administration Center (PAC) computer for consolidation and dissemination at that point.

c. Individual patient information to be transmitted to the PAC computer.

2. From the TASCUM computer, the PAC computer furnishes reports for the command surgeons, major medical commanders, and The Surgeon General prepared from information in the master medical records file. The file data will consist of all the individual patient transactions and facility status inputs. The file will provide an individual history of each patient from the time of initial admission to disposition.

(5) Summary. This automated system should provide reports that are more current, accurate, concise, and comprehensive than those now available. The system also provides for exception reports requiring management attention and special reports formulated from system interrogation.

c. Medical regulating.

(1) System description. Medical regulating is the coordination and control of the movement of patients to medical facilities which are best able to provide the required medical care. The medical regulating performed to govern the flow of patients into field army medical facilities is largely informal in nature. Control of patient evacuation from the treatment facilities of the division to hospitals of the field army is normally accomplished through "management by exception". Through the technique of mission assignment to operating ambulance units and hospitals, the anticipated flow of patients is established. Using a system of periodic and "spot" reports, the movement of patients is directed to prevent the overloading of hospital facilities and the development of surgical backlogs. Through a system of formal reporting, the medical regulating officers (MRO's) at medical group headquarters receive requests for evacuation of patients from each hospital within the group. The group MRO consolidates these requests and forwards them to the medical brigade MRO, who in turn consolidates them and forwards them to the medical command MRO. When approved and coordinated by the medical command MRO, the medical brigade and group MRO's arrange for the movement of patients to the appropriate air and rail heads. The medical command MRO controls the movement of patients from the combat zone into the COMMZ as well as the movement of patients within the COMMZ. The medical command MRO also consolidates requests for the movement of patients to CONUS and forwards the information to the Joint Medical Regulating Officer (JMRO) for appropriate action.

The medical regulating function includes the following:

(a) Collection and organization of patient and facility information which can be provided to the appropriate Medical Regulating Officer (MRO) in an expeditious manner.

(b) Consolidation and summarization of information by the MRO's who forward it to the next higher echelon.

(c) Scheduling the movement of patients based on:

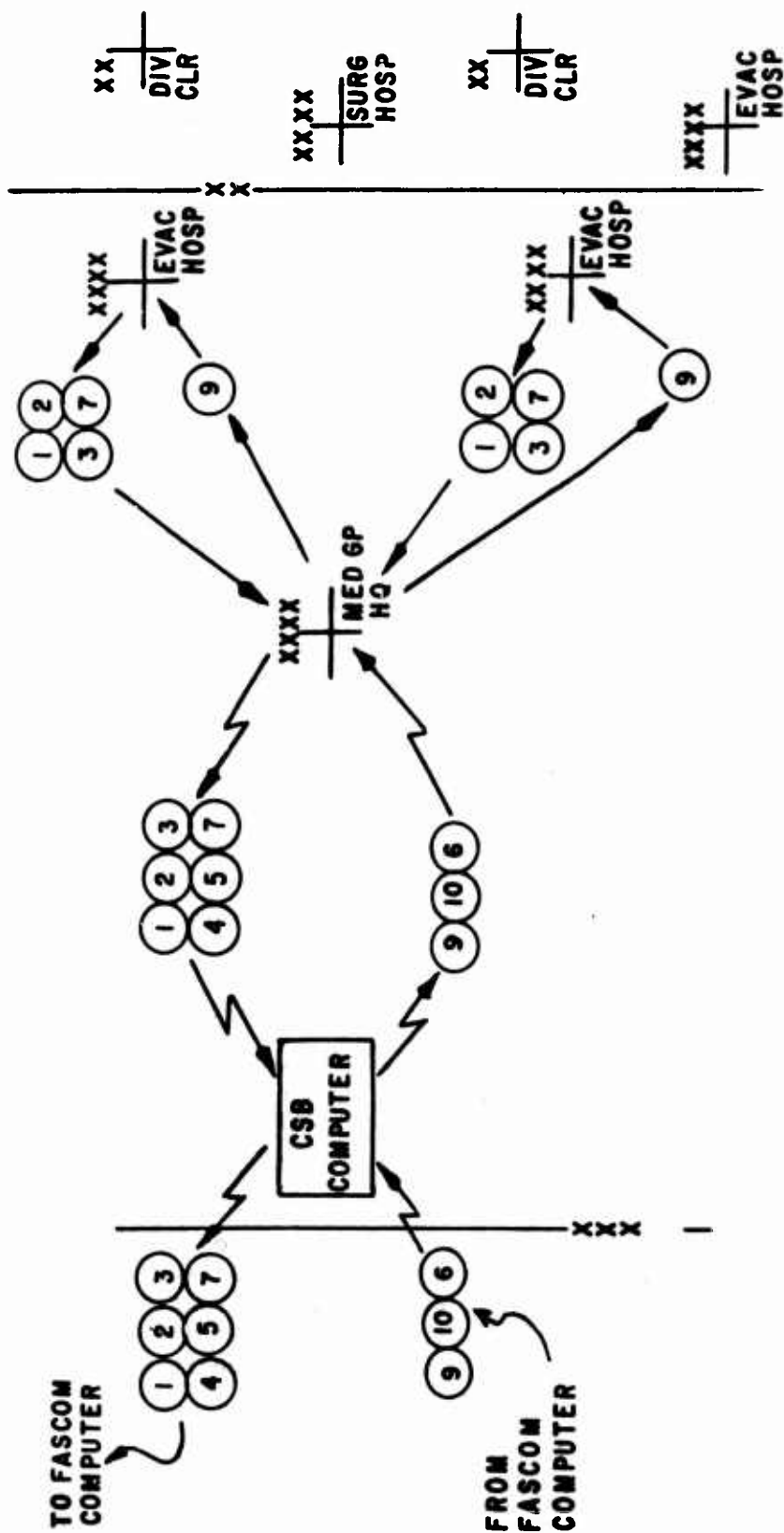
1. Tactical situation in the combat zone.
2. Availability of transportation.
3. Location of treatment facilities.
4. Current bed status of treatment facilities.
5. Surgical backlog of treatment facilities.
6. Medical resources available at each treatment facility.
7. Number and location of patients by diagnostic category.
8. Locations of airfields and railheads.
9. Patient's condition (suitably stabilized to withstand evacuation).
10. Evacuation policy.

(2) Current methods used to process and transmit information. Medical units collect, organize, consolidate, and summarize information using manual methods and procedures. The information flows through the system by telephone, teletype, radio, or when available, punch card equipment (see Figures F-2 and F-3).

(3) Interim techniques planned for installation by the end of CY 68. Units of the medical service will continue to collect, organize, consolidate, summarize and transmit medical regulating information in the same manner as presently performed. It is not planned to include the medical regulating function in any of the interim systems being developed.

(4) Introduction of CS₃.

(a) Method. With the introduction of CS₃, the medical regulating function will be performed using an automated method. Refer to Figures F-4, F-5, and F-6 for information flow.



LEGEND:

- | | |
|------------------------------------|-------------------------------|
| 1. MED FACILITY UPDATE TRANSACTION | 6 ON CALL REPORT |
| 2. EVACUATION REQUEST TRANSACTION | 7. ADMISSION TRANSACTION |
| 3. DISPOSITION TRANSACTION | 8. EVACUATION REQUEST REPORT |
| 4. INQUIRY | 9. EVACUATION SCHEDULE REPORT |
| 5. MANAGEMENT PARAMETER | 10. MED FACILITY REPORT |

FIGURE F-4 MEDICAL REGULATING INFORMATION FLOW FIELD ARMY

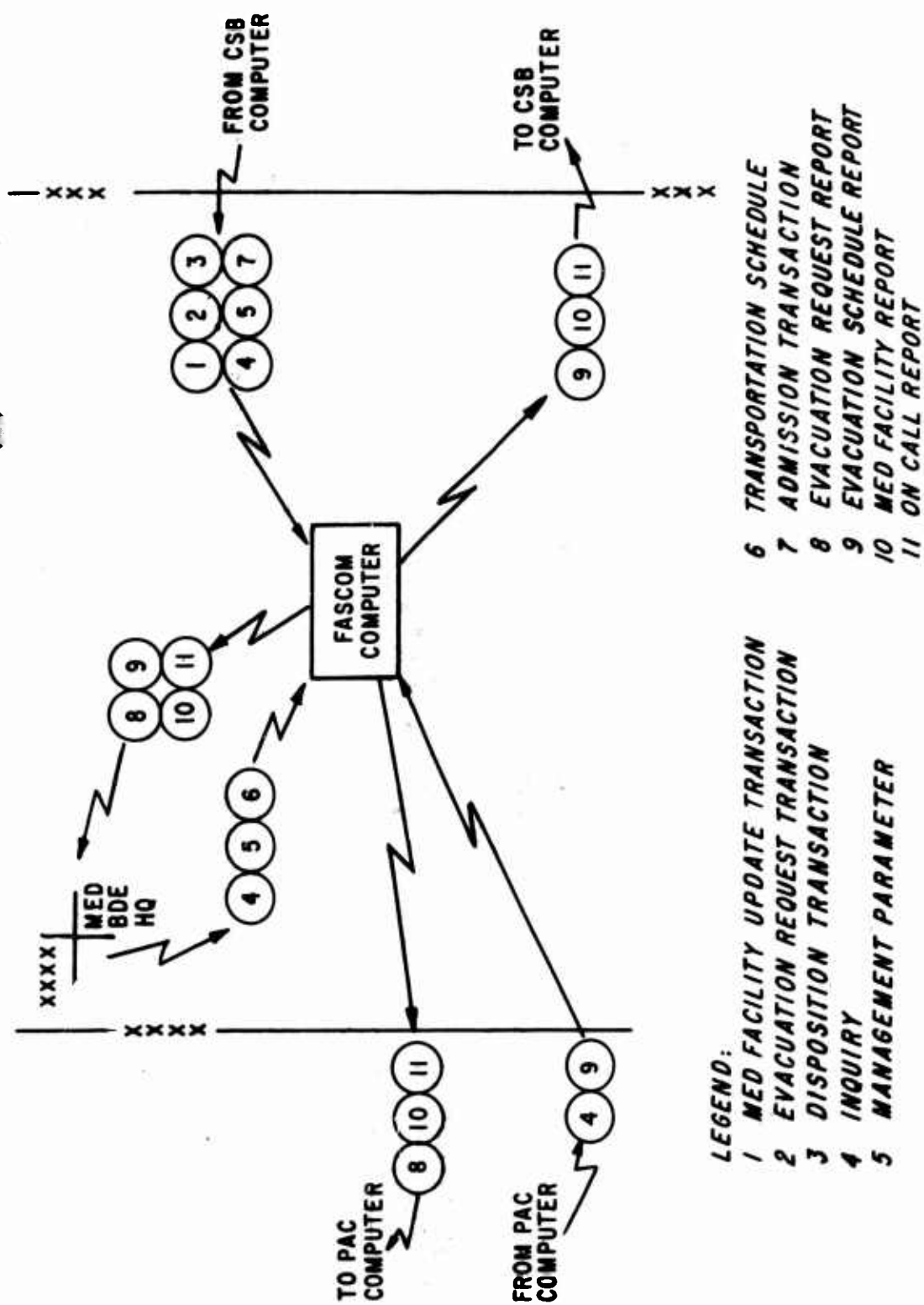


FIGURE F-5 MEDICAL REGULATING INFORMATION FLOW FIELD ARMY

(b) Data input.

1. Sources. The originators of input information for medical regulating at the field army level are the evacuation and surgical hospitals and, in COMMZ, the medical treatment facilities. The most common documents used are medical facility reports, evacuation requests, admissions and disposition (A&D) information, and inquiries. Input information received through the theater army level computer system includes evacuation schedules and inquiry transactions. The sources of input to the medical regulating function at the PAC computer include:

a. Reports prepared and received from the FASCOM computer.

b. Aircraft schedules received from the Aeromedical Evacuation Control Center (AECC).

c. Requests for ambulance train evacuation schedules which are entered by the medical command MRO and transmitted by the computer to the CS3 Movements Control Center (MCC) computer.

d. Management parameter and inquiry transactions.

e. Source documents from the medical groups and hospital centers organic to the medical command; medical facility reports; admission and disposition information and inquiries.

2. Transmission. The transmission of source information is via a means of communication which transmits information in the same language/format required for entry into the ADP system by on-line I/O devices, or by the inclusion of an input/output capability at the hospital level which would permit the entry of data through the appropriate medical headquarters to a central computer for consolidation and return. Admission/disposition and medical facility information will be transmitted as an integral portion of the patient accounting function.

3. Preparation. Source information received at the medical group headquarters in field army will be entered into the computer system via the group's remote I/O device, which will be on-line to the CS3 Corps Support Brigade (CSB) computer. The information will be switched by this computer to the CS3 FASCOM computer, where the processing will be accomplished. In COMMZ, the source information from hospitals is received at medical group or hospital center headquarters and transmitted using on-line I/O devices to the CS3 PAC computer. The management parameter transaction is used to enter management controls into the automated system. These controls provide a means for automatically producing exception reports and transmitting them to the MRO's for appropriate action, e.g., a parameter setting of 75 percent hospital bed occupancy would cause a message to be transmitted to the appropriate MRO for his attention when that occupancy level was reached or exceeded. An inquiry is used to initiate the production of a requested report such as a medical facility status report.

(c) Output. The outputs of the medical regulating function at the field army level (FASCOM computer) and COMMZ level (PAC computer) may be divided into three categories:

1. Reports.
2. Requests to be transmitted to higher echelons.
3. Responses to requests originating at lower echelons.

(5) Summary. This automated system will provide medical regulating officers with a more efficient method to manage the evacuation of patients. Information received can be expected to be more current, accurate, concise, and comprehensive than now available. Exception reports should be more timely and meaningful.

d. Medical supply.

(1) Introduction. Wherever the term supply is used herein it is termed to mean both supply and maintenance. The COMMZ medical depots provide support to the field army and to the COMMZ. The army medical depot consists of a base and three advance platoons. The base platoon has the responsibility for supporting units within the army rear area and the advance platoons. The advance platoons have the responsibility for supporting units in the corps area. The army medical depot will operate the medical supply ICP for the field army using an automatic data processing device. It is not anticipated that there will be any requirement for support from the CS3 ADSAF system other than communication linkage support. Within the COMMZ, supply operations will be managed at the medical command, utilizing the appropriate CS3 computer and communication network. The medical supply ICP will be centralized at the medical command. When only one COMMZ medical depot is assigned to the TASCOR, the ICP may be located at this depot. Each depot and the medical command headquarters will have some type of automatic data processing equipment to facilitate medical supply and maintenance operations within COMMZ. The medical supply function includes the following:

(a) Collection and processing of requests for material for transmission to the appropriate supply point.

(b) Inventory management and stock control in accordance with AR 725-50 and AR 711-16.

(c) Dissemination of data and reports locally and to higher and lower echelons in response to requisitions and requests for status information.

(2) Current methods used to process and transmit information.

(a) At the retail level, there will be no change from the current method. Customers will manually prepare their requests in accordance with AR 725-50 and AR 711-16, forward them to the supporting supply installation by available communication means.

(b) Currently, most wholesale level medical supply operations, including inventory and stock control, are performed with automatic data processing equipment (ADPE) methods and procedures. The systems in use are not uniform because the equipment has not been standardized. These systems and procedures will continue for the present (See Figure F-3).

(3) Interim techniques planned for installation by the end of CY 68. The army medical depot in field army and the medical command in COMMZ will each operate ICP's. Supply operations will be supported through the use of an automatic data processing device located at the field army medical depot, each COMMZ depot, and the medical command ICP. Improvements in the manual preparation and handling of supply requests will be incorporated as they occur.

(4) Introduction of CS₃.

(a) Data processing. With the introduction of CS₃, additional automation will be made available to support the medical supply function. The CS₃ data processing and communication system will assist the ICP at the army medical depot and the medical command in performing its medical supply management mission. Processing of medical supply and maintenance data will be accomplished on the ADP equipment located at the army medical depot and COMMZ medical command ICP. The CS₃ computer system will provide a communications linkage between the sender/receiver and the computer performing the processing/storage function. (See Figure F-7 for Field Army; F-8 for COMMZ).

(b) Data input.

1. Sources. The sources of input information are the consuming units, the field army, and the COMMZ medical depots.

2. Transmission. Normally, source document information will be transmitted via ADPE or by other communication means.

3. Preparation. Source information requiring computer processing is entered into the system via the remote on-line I/O device. This information is switched to the appropriate ADP center where processing is accomplished. Types of information include the following:

- a. Requisitions for material.
- b. Advice and status documents.
- c. Shipment and receiving documents.
- d. Standard requests for information.
- e. Management parameters.
- f. Other MILSTRIP transactions.

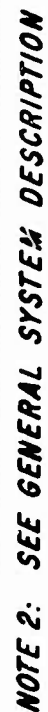


FIGURE F-7 MEDICAL SUPPLY INFORMATION AND MATERIEL FLOW:

GENERAL SYSTEM DESCRIPTION

A general description of the field army medical supply system is provided in Figure F-7 and in the following discussion which is keyed to the figure:

1. Requests for material are forwarded from the medical companies, in support of each brigade, to the medical battalion. The means of communication may be ambulance or other vehicles or by the existing communication network.
2. Depending on the urgency of the situation and availability of supplies, material is either furnished by the battalion supply section or the requirement may be forwarded to the advance platoon of the medical depot.
3. Materiel available from the battalion supply section is dispatched forward by returning ambulances, or by other vehicles or aircraft.
4. Requests for replenishment of division stocks, emergency, and fringe requirements are forwarded to advance platoon of the medical depot which has responsibility for corps support. Such requests can be forwarded by ambulances, other vehicles or aircraft, or by normal communications means.
5. Depending on the urgency of the requirements and the availability of stocks, the requirement will either be filled, placed on back order, or forwarded to field army medical depot.
6. Materiel that is available is dispatched to either the medical battalion or direct to the medical company. The material will normally be transported either by returning ambulances, other vehicles or aircraft.
7. Requests for replenishment of hospital supplies, emergency, and fringe requirements are forwarded to the advance platoon. Such requests can be forwarded by ambulance, other vehicles or aircraft, and other available communications means.
8. Materiel that is available is normally transported to the hospitals by ambulances or other medical vehicles.
9. Requisitions for replenishment of the advance platoon stocks and requests that are being referred due to their urgency are forwarded to the medical ICP at the field army medical depot via the CS₃ communication system.
10. The ADP support for both inventory control and stock control are performed at this echelon for field army medical depot material. Depending on the urgency of the requirement and the availability of materiel, a Materiel Release Order (MRO) is initiated, the requirement is placed on back-order against materiel due in from COMMZ, or the requirement is referred to COMMZ for delivery.

11. Information transactions such as status and notice of shipment are transmitted to the medical supply advance platoon via the CS3 communication system.

12. Materiel Release Orders and other supply type directives are transmitted to base platoon via the CS3 communication system.

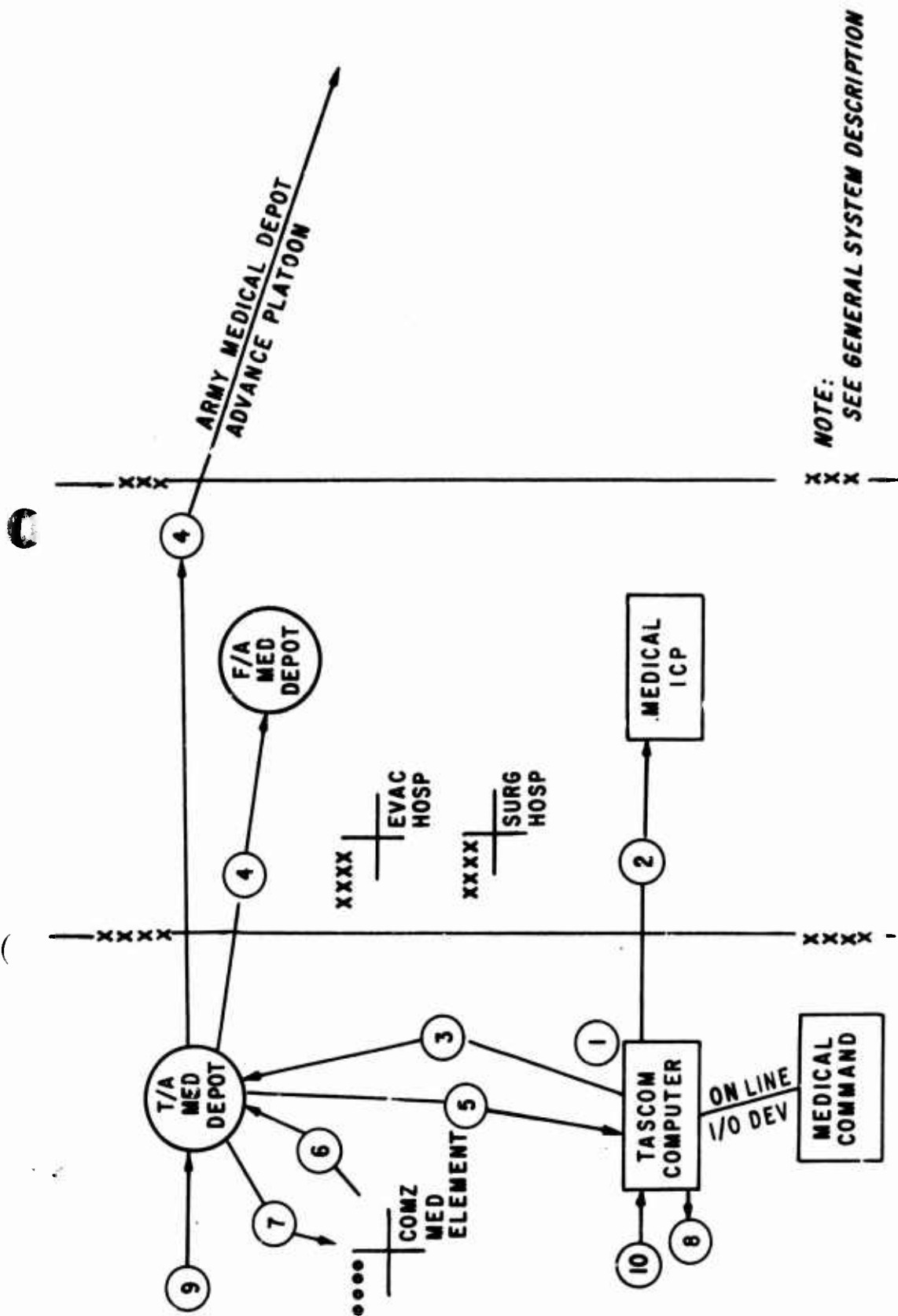
13. The base platoon performs the normal warehouse and maintenance functions to accomplish both general and direct support activities.

14. Requests and issues to consuming units in the army service area are processed in manner similar to that used by the advance platoon.

15. Materiel is shipped from the base platoon to either the advance platoon, or division rear. Shipment normally is by ambulances or medical vehicles.

16. The base platoon forwards normal supply transactions such as reports of receipts, inventories and shipments via the CS3 communication system.

17. Requisitions for replenishment of the field army medical depot and other high priority demands are transmitted to the medical command ICP through the TASCOM computer supporting the COMMZ medical function.



NOTE: SEE GENERAL SYSTEM DESCRIPTION

FIGURE F-8 MEDICAL SUPPLY INFORMATION AND MATERIEL FLOW

GENERAL SYSTEM DESCRIPTION

A general description of the communications zone medical supply system is provided in Figure F-8 and in the following discussion which is keyed to the Figure.

1. The ADP support for inventory management is performed at this echelon for COMMZ medical stocks.
2. Informational transactions such as status and shipment documents are transmitted through the FASCOM computer to the field army medical inventory control point.
3. Materiel Release Orders and other supply type transactions are transmitted from the TASCOM medical ICP through the appropriate TASCOM computer to the medical depots.
4. The materiel is normally shipped to the proper destination by medical or TASCOM transportation means.
5. The depot communicates normal supply transactions such as reports of shipments, receipts, and inventories to the appropriate TASCOM computer and the TASCOM medical ICP.
6. Requisitions are received from COMMZ medical elements such as hospital centers, general hospitals, medical groups, and field hospitals.
7. Materiel is normally forwarded to the COMMZ medical elements by medical vehicles.
8. Replenishment requisitions and high priority demands are transmitted to the CONUS.
9. Material from the CONUS is shipped to the medical depots.
10. Notice of shipment and other routine supply transactions are received by the TASCOM medical ICP through the appropriate TASCOM computer.

(c) Output. The outputs of the medical supply functions include:

1. Daily status.
2. Monthly status.
3. Monthly summary.
4. Quarterly status and summaries.
5. Yearly status and summaries.
6. Special or demand reports.
7. Status information to CONUS.

(5) Summary. The above will provide a medical supply and distribution system which will be more progressively responsive to theater requirements and phased to ADPE implementation.

e. Interface with CONUS data systems. Current data transmission means will continue to be used to connect the various systems. Automatic data processing equipment will be used when available. With the introduction of CS₃, the Medical Service will use the communications network associated with this system to interface with CONUS.

f. Alternate methods. Alternate data processing procedures will be as indicated below in the event of temporary or total disruption of automatic data processing means.

(1) Until the introduction of CS₃, no alternate system need be specified for medical regulating and patient accounting/reporting since current methods and those planned for the immediate future are performed primarily using manual systems, methods and procedures. With the introduction of the CS₃ program, the medical service will rely upon the alternate equipment, methods and procedures being developed for the CS₃ program. In addition, a limited manual capability will be retained.

(2) The medical supply ICP's in the field army and COMMZ will need a manual backup capability to provide continuity of supply operations.

4. Conclusions.

a. Until the introduction of CS₃, the medical service functions of medical regulating and patient accounting/reporting will be accomplished using present or improved manual methods and procedures.

b. The medical supply system will establish an ICP at the army medical depot for field army and at the medical command for COMMZ. To support the medical supply system, automatic data processing equipment

will be required for each medical depot and the medical command headquarters.

c. The interface with CONUS data systems will be via existing data transmission means until the introduction of CS₃.

d. The inclusion of ADPE at the medical depot level will not generate temporary TOE changes during the interim period prior to CS₃.

ANNEX G

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13. ABSTRACT This study presents the functions, organization, and concepts of operation of an Army-wide medical service within a theater of operations for TASTA-70. The Medical Brigade, FASCOM, supports the field army through the employment of subordinate control headquarters, hospitals, evacuation units, and other medical service organizations. The Medical Command, TASCAM, provides command, planning, and continuous operation of the theater-wide medical service by relieving the field army of its patients and providing them hospitalization in the COMMZ. TASCAM is furnished medical service on an area basis. Where appropriate, medical service functions were adapted to automated systems. Type medical service support organizations were structured for twelve, eight, three, and one division forces.		

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